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The Duality of Provider and Payer in the Current Healthcare Landscape and Related Antitrust Implications

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The Duality of Provider and Payer in the
Current Healthcare Landscape and
Related Antitrust Implications

JULIA KAPCHINSKIY*

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I. INTRODUCTION: HEALTHCARE’S BLURRED LINES

What happens when a drugstore buys a health insurance company? A deal of this kind seemed unthinkable until retail pharmacy giant CVS stepped forward with a \$69 billion offer to buy Aetna, one of the major players in the US health insurance market.¹ The merger was announced in late 2017 and is expected to close in late 2018, subject to approval by shareholders of both companies and regulators.² This deal, which further blurs the lines between “traditionally separate spheres” of the healthcare industry,³ represents the increasingly popular effort to change the care delivery mechanisms and to make healthcare more available. In addition to its drugstores, CVS operates CVS MinuteClinic walk-in clinics and CVS

1. Michael J. de la Merced & Reed Abelson, *CVS to Buy Aetna for \$69 Billion in a Deal that May Reshape the Health Industry*, N.Y. TIMES (Dec. 3, 2017), <https://www.nytimes.com/2017/12/03/business/dealbook/cvs-is-said-to-agree-to-buy-aetna-reshaping-health-care-industry.html>; Robert Langreth et al., *CVS-Aetna Deal May Hinge on Antitrust Approach Under Trump*, BLOOMBERG (Dec. 3, 2017, 9:01 PM), <https://www.bloomberg.com/news/articles/2017-12-04/cvs-aetna-takeover-may-hinge-on-antitrust-approach-under-trump>.

2. See Merced & Abelson, *supra* note 1. It is still not clear whether the deal will be approved by the antitrust agencies, but the proposed transaction is unprecedented in size and market segments represented. See Langreth et al., *supra* note 1.

3. Merced & Abelson, *supra* note 1.

Caremark, a pharmacy benefit manager.⁴ One can certainly envision customers—insured through Aetna—walking into a CVS MinuteClinic to take care of such needs as: a quick flu shot; a check-up determining a need for an antibiotics prescription that can be filled right on site; discounted prescription drugs through CVS Caremark; or a convenient visit to a walk-in clinic at a local drugstore that allows avoiding a costly trip to the emergency room.

Although healthcare is one of the most traditional industries, it is currently undergoing a transformation that is leading to the development and testing of new strategies, new products, and maybe even new markets that have not been previously considered.⁵ Insurance companies attempt to consolidate—although unsuccessfully at this point.⁶ Patient-centric services are blossoming.⁷ Hospitals start their own insurance plans.⁸ As discussed above, retail pharmacies propose to acquire insurance businesses.⁹ Employers create their own accountable care organizations (ACOs).¹⁰ Moreover, the “blue chips of Silicon Valley” have made public their intention to bring the tech market efficiencies into the traditionally inefficient healthcare market.¹¹

4. Jacob Passy, *What the CVS-Aetna Deal Means for You*, MARKETWATCH (Dec. 4, 2017, 5:50 PM), <https://www.marketwatch.com/story/how-the-cvs-aetna-deal-could-actually-benefit-consumers-2017-10-27>.

5. Fiona Scott Morton, Yale economist and former head economist for the U.S. Department of Justice, views “a new sort of industry . . . or a new kind of problem” as a “fun and interesting and novel” aspect of antitrust mostly due to the fact that “nobody has quite figured out what’s legal and what’s not legal.” Fiona M. Scott Morton, *Is Antitrust Law Keeping Up?*, YALE INSIGHTS (July 12, 2013), <https://insights.som.yale.edu/insights/is-antitrust-law-keeping-up> [<https://perma.cc/97F4-T5RL>]. Although she is not applying this fully and particularly to healthcare, her approach can certainly be extended to it. There is too much going on in healthcare to have a clear *prescription* of the legality in antitrust sense.

6. Consolidation attempts between the insurance giants have been unsuccessful in the past few years. Just recently, Aetna’s merger with Humana and Anthem’s merger with Cigna were banned, as these proposed transactions would highly concentrate the insurance market in the United States and limit it to just three major players. *See generally* *United States v. Anthem, Inc.*, 855 F.3d 345 (D.C. Cir. 2017); *United States v. Aetna, Inc.*, 240 F. Supp. 3d 1 (D.C. Cir. 2017).

7. *See infra* text accompanying note 114.

8. *See infra* note 131 and accompanying text.

9. *See supra* text accompanying note 1.

10. *See infra* text accompanying note 107.

11. Dylan Scott, *Why Apple, Amazon, and Google are Making Big Health Care Moves: Silicon Valley Wants to Disrupt Your Health Care*, VOX (Mar. 6, 2018, 9:00 AM), <https://www.vox.com/technology/2018/3/6/17071750/amazon-health-care-apple-google-uber> [<https://perma.cc/R3G5-VSHF>].

Amazon is rumored to be preparing to enter the pharmacy business and provide a technological platform for administering healthcare in a partnership with JPMorgan Chase and Berkshire Hathaway.¹² Apple is designing a line of medical clinics.¹³ Google is eyeing the Medicaid market administration of services through its sister company Verily.¹⁴ Uber is planning to allow healthcare providers to book rides for their patients and be reimbursed for it through insurance.¹⁵ Overall, the border between healthcare service provider, insurer, and beneficiary is becoming vaguer than ever before, and competition appears where it was previously unimaginable.

Healthcare in the United States is designed as a business¹⁶ and operates in an environment where contracts are as important as taking care of a patient and increasing costs are as much a concern as favorable treatment outcomes. Similar to any business, this environment fosters competition, which accordingly serves as one of its crucial drivers.

Antitrust laws regulating all industries equally apply to healthcare. Despite its traditionally inherent social nature, the regulators primarily view healthcare organizations as businesses that “provide medical services.”¹⁷ Judge Bork suggested antitrust laws serve as a “consumer welfare prescription,”¹⁸ no pun intended. This prescription, however, does not differentiate between industries. There is no separate prescription for how to achieve consumer

12. *Id.*; see also Nick Wingfield & Katie Thomas, *Hearing Amazon’s Footsteps, the Health Care Industry Shudders*, N.Y. TIMES (Oct. 27, 2017), <https://www.nytimes.com/2017/10/27/technology/amazon-pharmacy-drugs.html?dlbk>.

13. Scott, *supra* note 11.

14. *Id.*

15. *Id.*

16. National health spending in 2016 constituted \$10,348 per person, or \$3.3 trillion overall, and accounted for 17.9% of Gross Domestic Product (GDP). Ctrs. for Medicare & Medicaid Servs., *NHE Fact Sheet*, CMS.GOV (Feb. 14, 2018, 3:16 PM) [hereinafter *NHE Fact Sheet*], <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html> [https://perma.cc/FQ8J-KC9R]. Health spending is projected to exceed GDP growth by 1% per year and therefore will constitute 19.7% of GDP by 2026. *Id.* To put facts in perspective, defense spending constituted around 3.2% of GDP in 2016. U.S. Cong. Budget Office, *Defense Outlays and Forecast in the United States from 2000 to 2028 (as a Percentage of the GDP)*, STATISTA, <https://www.statista.com/statistics/217581/outlays-for-defense-and-forecast-in-the-us-as-a-percentage-of-the-gdp/> [https://perma.cc/DX9H-3B8V].

17. Peter J. Hammer & William M. Sage, *Critical Issues in Hospital Antitrust Law*, 22 HEALTH AFF. 88, 88 (2003), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.22.6.88> (suggesting antitrust regulations focus on the behavior of hospitals and not on their objective because hospitals are “simply business firms organized to provide medical services”); see also William M. Sage et al., *Why Competition Law Matters to Healthcare Quality*, 22 HEALTH AFF. 31, 34 (2003), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.22.2.31> (describing healthcare as a “big business” with price competition as an integral element, similar to any other business).

18. ROBERT H. BORK, *THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF* 66 (1993).

welfare in the application of antitrust laws as applied to healthcare specifically.¹⁹ Still, antitrust laws, in addition to privacy laws and medical malpractice, are one of the vehicles that have molded the business of medicine by influencing the conduct of multiple parties engaged in providing care and by dictating how delivery of care can be structured.²⁰

The business of healthcare is currently undergoing yet another transformation caused primarily by the Affordable Care Act (ACA)²¹—a transformation that antitrust watchdogs have failed to perceive.²² The ACA came into effect in 2010²³ and by 2018 has essentially been embraced by the entire healthcare industry.²⁴ It aims to overturn the reimbursement-

19. Enforcement of antitrust principles in healthcare technically started in 1975 when the Supreme Court decided “learned profession[s]” do not enjoy antitrust exemption. *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975). Pre-*Goldfarb* federal authorities disregarded the healthcare sector—be it because of the exemption interpretation or because of lack of expertise, the medical field is a complex industry and quite often is considered *untouchable* due to its complexity. Post-*Goldfarb* antitrust enforcement expansion to healthcare, however, did not adjust its standard principles to the unique nature of healthcare. Competition in the medical field is viewed the same way as competition in selling pens or manufacturing cars. The paradox is that *Goldfarb* has no mention of *healthcare* or *medicine*. See generally *id.* It is a case examining price fixing by lawyers and the related violation of the Sherman Act. See generally *id.* Extension of the “learned profession” to medicine is what made *Goldfarb* the seminal case for healthcare antitrust law. *Id.* at 787. Another paradox is that *Goldfarb* specifically notes special accommodations may be necessary. *Id.* at 792–93. Where does this sweet spot between competition and collaboration in “learned professions” belong? *Id.* at 787.

20. “Between 1985 and 1999 hospitals were defendants in 61[%] of . . . medical antitrust disputes.” Hammer & Sage, *supra* note 17 (citing Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 565 (2002)). However, this number is probably significantly less than the number of claims that were actually filed. See *id.* Most claims against hospitals result in a settlement, in which case no published judicial opinion or official record is available. *Id.*

21. See generally Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. §§ 18001–18122 (2018)).

22. However, it is undisputed by the officials that the ACA “only increases th[e] importance” of antitrust enforcement on the healthcare industry through “the prospect of expanded consumer choice.” *Antitrust Laws and Their Effects on Healthcare Providers, Insurers and Patients: Hearing Before the Subcomm. on Courts & Competition Policy of the H. Comm. on the Judiciary*, 111th Cong. 46 (2010) [hereinafter *Hearing*] (statement of Sharis A. Pozen, Chief of Staff and Counsel to the Assistant Att’y Gen., Antitrust Division, U.S. Department of Justice).

23. See Patient Protection and Affordable Care Act, 124 Stat. at 119.

24. See Shefali Luthra, *Doctors Used to Be the Greatest Opponents of Universal Health Care. Now They’re Embracing It*, MONEY (Aug. 8, 2018), <http://time.com/money/5360985/doctors-single-payer-healthcare/>. Repeal or replacement of the ACA is beyond the scope of this Comment, which treats the ACA as continuing indefinitely. In the unlikely event the ACA

oriented mentality of healthcare providers.²⁵ Specifically, it calls for changes in the classical approach of “Fee-For-Service” (FFS) which most consumers have faced when seeking medical care.²⁶ Under the ACA, it is no longer sufficient to treat only the issue causing the visit; instead, the emphasis is on treating the patient holistically.²⁷ The holistic approach to medicine²⁸ requires reassessment of how care is provided and, consequentially, invokes the need for a new approach to regulations. The discussion of such an approach and how it should be treated concentrates around competition and respective anticompetitive practices because the change process²⁹ is twofold: (1) healthcare *businesses* must find new ways to cooperate, collaborate, and yet still remain profitable, and (2) antitrust regulators must ensure the integrity of such practices.³⁰

Both federal and state laws regulate the healthcare industry.³¹ This Comment primarily focuses on the enforcement of federal antitrust laws, particularly their interaction with the healthcare industry in the post-ACA enactment era. Integration in healthcare has blossomed since the ACA became law. Accountable Care Organization (ACO) structure has gained

is repealed, it would have no measurable impact on the development of the competition phenomena described in this Comment; the mechanism of change has been launched and cannot be easily stopped even by the repeal of a significant legislative vehicle.

25. The ACA drastically reduced volume-based “Fee-For-Service (FFS) payments,” deeming them ineffective, and replaced them with “Value Based Purchasing” (VBP)—commonly referred to as *pay-for-performance*—payments. Brandon Bowling et al., *Provider Reimbursement Following the Affordable Care Act*, in BUSINESS AND HEALTH ADMINISTRATION PROCEEDINGS 168, 169, 173 (Avinandan Mukherjee ed., 2017). One of the key differences between the two methods is VBP focuses on quality of care rather than the volume of services provided and charged for. *Id.*

26. *See id.*

27. *See* Kenneth L. Davis, *Hospital Mergers Can Lower Costs and Improve Medical Care*, WALL ST. J. (Sept. 15, 2014, 7:17 PM), <https://www.wsj.com/articles/kenneth-l-davis-hospital-mergers-can-lower-costs-and-improve-medical-care-1410823048>.

28. *See, e.g.*, Alan Spiro & Adam Perlman, *A Holistic Approach to Healthcare Can Lower Costs and Improve Quality*, H&HN (Aug. 4, 2016), <https://www.hhnmag.com/articles/7508-the-case-for-a-holistic-approach-to-health-care> [<https://perma.cc/R9H5-RDVF>] (explaining the holistic approach to medicine places the patient in the center of care and embraces prevention and well-being as healthcare goals equally important to treating illness).

29. Namely, moving from today’s practically nonexistent regulations—as this Comment will discuss *infra* Part III—to something else entirely.

30. FED. TRADE COMM’N & U.S. DEP’T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 43 (2004) [hereinafter IMPROVING HEALTH CARE] (“[H]ealth care is not a natural monopoly, and . . . competition has an important role to play in ensuring that consumers can obtain the care they desire at a price they are willing to pay.”).

31. *See* Kellyn Norris, *Governments Work to Improve Health Care Regulation*, U.S. NEWS (Nov. 4, 2016, 11:57 AM), <https://www.usnews.com/news/healthcare-of-tomorrow/articles/2016-11-04/federal-state-governments-work-to-address-health-care-regulation>.

popularity among providers,³² vertical integration has increased tremendously,³³ and “population health”³⁴ has become the new financial model. Medicare has introduced innovative models to reduce reimbursement, and healthcare providers are under pressure to cut costs. Collaboration and integration have become elements of cost containment—from caring for the patient to creating new ways to engage consumers with the focus to better understand consumer behavior³⁵ and correspondingly motivating patients to use the provider. Antitrust regulations in healthcare have failed to adequately capture and address the rapid development of the healthcare industry over the past ten years. This Comment asserts that the majority of strategic development and structural innovation in the past decade has been undertaken to control the patient and ultimately capture market share.

Part II of this Comment summarizes the current state of antitrust regulations in the healthcare field by briefly describing the major applicable antitrust laws and the enforcing federal agencies. The assumption is that antitrust regulations are intended to provide for equal participation and to prevent unfair advantages to certain players for reasons outside of *regular* competition.

Part III examines emerging trends in the healthcare continuum and the challenge they pose to standard antitrust principles. Specifically, it explores provider integration, innovation, and experimentation in the healthcare organization structure that enable risk- and cost-sharing and expand control over the patient. Part III also outlines why current regulations do not ensure

32. See, e.g., Jacqueline LaPointe, *Accountable Care Organizations Continue to Grow with 11% Boost*, REVCYCLE INTELLIGENCE (June 29, 2017), <https://revcycleintelligence.com/news/accountable-care-organizations-continue-to-grow-with-11-boost> [https://perma.cc/PP95-7K95].

33. See, e.g., Laura Dyrda, *Healthcare Transactions in the Era of Megamergers and Vertical Integration*, BECKER'S HOSP. REV. (Feb. 12, 2018), <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/healthcare-transactions-in-the-era-of-megamergers-and-vertical-integration-q-a-with-jeff-swearingen.html> [https://perma.cc/TAA5-63XV].

34. Originally coming from Canada, “population health” management entered the United States of America in late 1990s to early 2000s but became widespread with the enactment of the ACA. David Kindig & Greg Stoddart, *What is Population Health?*, 93 AM. J. PUB. HEALTH 380, 380 (2003). The term is defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.” *Id.*

35. KPMG Strategy, for example, differentiates this technique from the traditional function of patient experience departments, which focuses on providing the service to existing patients. Lara Ramos Hegwer, *New Structures, New Roles for the Future of Health Care*, LEADERSHIP+ (Apr. 27, 2016), http://www.hfma.org/Leadership/Archives/2016/Spring/New_Structures,_New_Roles_for_the_Future_of_Health_Care [https://perma.cc/QKB2-2V2H].

the equality of players in the field. The premise is that the current regulatory framework is set up to allow larger health systems to engage in collaborations through means directly and indirectly provided by the ACA without being scrutinized by the antitrust enforcement agencies and to disadvantage smaller organizations—standalone hospitals or individual physician practices—that are seeking entry to novel practices, such as accountable care organizations, self-funded insurance mechanisms, and engagement in population health strategies.

Part IV lays out the proposed solution to the alleged competitive inequality by explaining which areas of the existing healthcare antitrust regulations should be adjusted to address the recent trends in healthcare, such as ACOs, vertical integration between healthcare organizations, provider-owned health plans—all developments where a healthcare provider takes on full control over the patient and eliminates intermediaries such as *classic* insurance companies.

Part V provides an assessment of how the changes or absence thereof will impact the competition and the subsequent development of healthcare in the United States.

II. ANTITRUST LAWS AND ENFORCEMENT AGENCIES

Scope of federal antitrust law is broad and has a long history that explains the current regulatory construction. This section provides a brief overview of legislative provisions governing healthcare antitrust enforcement, explains how such enforcement actually occurs, describes what healthcare antitrust is, and, more importantly, what it is not.

A. *Federal Antitrust Law in Healthcare*

The Sherman Antitrust Act of 1890 (Sherman Act)³⁶ is the key federal antitrust provision passed by Congress as a “comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade.”³⁷ Section 1 of the Sherman Act prohibits contracts, combinations, and conspiracies “in restraint of trade or commerce,”³⁸ whereas § 2 makes it illegal “to monopolize, or attempt to monopolize, or combine or conspire with any other person or persons.”³⁹ The Sherman Act carries

36. Sherman Antitrust Act of 1890, ch. 647, 26 Stat. 209 (codified as amended at 15 U.S.C. §§ 1–7 (2018)).

37. *The Antitrust Laws*, FED. TRADE COMMISSION, <https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws> [<https://perma.cc/TU64-DN3L>].

38. 15 U.S.C. § 1.

39. *Id.* § 2.

both civil and criminal penalties.⁴⁰ Criminal prosecution under the Sherman Act may be brought by only one federal agency: the United States Department of Justice (DOJ).⁴¹ In 2016, the DOJ tried fifty-one criminal cases, compared to its peak in 2011 with ninety cases, and recovered \$399 million in criminal fines and penalties.⁴²

The Federal Trade Commission Act of 1914 (FTCA) has the power to prohibit “[u]nfair methods of competition in . . . commerce, and unfair or deceptive acts or practices.”⁴³ In 1948, the United States Supreme Court held that all violations of the Sherman Act also violate the FTCA.⁴⁴ However, distinct from the Sherman Act, the FTCA provides only civil remedies.⁴⁵ The FTCA created the Federal Trade Commission (FTC) to enforce the Act with authority over a range of activities.⁴⁶ The FTCA does not technically apply to not-for-profits, a point of significant importance in the healthcare context.⁴⁷ Not-for-profit hospitals were originally exempt from the FTCA,

40. *Id.* § 1 (imposing criminal penalties of up to \$100 million for a corporation and \$1 million for an individual, along with up to ten years in prison).

41. *See id.* § 4; ANTITRUST DIV., U.S. DEP’T OF JUSTICE, AN ANTITRUST PRIMER FOR FEDERAL LAW ENFORCEMENT PERSONNEL 1 (2005) (“Price fixing, bid rigging, and market allocation are economic crimes [that] rob purchasers, contribute to inflation, destroy public confidence in the economy, and undermine our system of free enterprise.”).

42. *Criminal Enforcement: Trends Charts Through Fiscal Year 2017*, U.S. DEP’T JUST. (Mar. 12, 2018), <https://www.justice.gov/atr/criminal-enforcement-fine-and-jail-charts> [<https://perma.cc/BU7G-P27Q>]; *see also The Antitrust Laws*, *supra* note 37.

43. 15 U.S.C. § 45(a)(1).

44. *The Antitrust Laws*, *supra* note 37 (alluding to *FTC v. Cement Inst.*, 333 U.S. 683, 694 (1948) (“[C]onduct violative of the Sherman Act may likewise come within the unfair trade practice prohibitions of the Trade Commission Act . . .”).

45. 15 U.S.C. § 45(m) (penalizing those who violate the FTCA with “a civil penalty of not more than \$10,000 for each violation”).

46. *Id.* § 45(a)(2) (enabling the FTC to prevent “unfair methods of competition . . . and unfair or deceptive acts or practices” by individuals, partnerships, and corporations). “[T]he FTC is dedicated to advancing consumer interests while encouraging innovation and competition in our dynamic economy.” *What We Do*, FED. TRADE COMMISSION, <https://www.ftc.gov/about-ftc/what-we-do> [<https://perma.cc/DA7K-S893>]. This broad language means the FTC is in charge of policy development, conducting investigations, and pursuing legal action when antitrust violations are discovered. It also means the FTC is at least partially in charge of interpreting what an antitrust violation is. *See id.* Because all violations of the Sherman Act also violate the FTCA, the FTC is empowered to pursue violations of the Sherman Act as well, even if indirectly through the FTCA.

47. Authority of the FTC to enforce the FTCA extends only to corporations that are carrying on business for their own or their members’ profit. *See* 15 U.S.C. § 45(a)(2); *see also* Eric S. Berman & Shahin O. Rothermel, *Court Upholds FTC Jurisdiction over Common Carrier: Nonprofits Should Take Heed*, VENABLE LLP (May 11, 2015), <https://www.venable.com/court-upholds-ftc-jurisdiction-over-common-carrier-nonprofits->

but the courts have since extended its application to non-profit corporations that are operated for their own profit or that of their members.⁴⁸ Thus, the FTCA is now relevant to the non-profit arena of healthcare.⁴⁹

Congress passed the Clayton Antitrust Act of 1914 (Clayton Act) to clarify the kinds of practices prohibited by the Sherman Act.⁵⁰ The language of the latter is broad and has been open to court interpretation,⁵¹ which have consistently prevented “unreasonable restraint of trade.”⁵² The Clayton Act prevents “trusts, conspiracies, and monopolies in their incipiency and before consummation.”⁵³ Unlike the Sherman Act, which it is intended to

should-take-heed-05-11-2015/ (“The FTC . . . usually refrains from pursuing enforcement actions against corporations that have been recognized as exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code, because these entities carry on business in pursuit of their tax-exempt purposes rather than for their own profit or that of their members. . . . The FTC has taken action against nonprofits in certain cases and will doubtless continue to do so when it believes an investigation or enforcement action is warranted.”). According to the American Hospital Association (AHA), more than 80% of hospitals in the U.S. are government run or not-for-profit. *See Fast Facts on US Hospitals, 2018*, AM. HOSP. ASS’N (Feb. 2018), <https://www.aha.org/statistics/fast-facts-us-hospitals> (in 2018, out of 5,534 registered hospitals, only 1,035 were investor owned for-profit community hospitals). This said, if non-profits were exempt from the FTCA, a majority of US hospitals would automatically enjoy such exemption.

48. *See* FTC v. Nat’l Comm’n on Egg Nutrition, 517 F.2d 485, 487–88 (7th Cir. 1975) (holding that the FTCA does apply to for-profit organizations and physicians in private practice); Cmty. Blood Bank v. FTC, 405 F.2d 1011, 1019 (8th Cir. 1969) (holding that when corporations organized under nonprofit laws engage in profit-making or other activities, they may lose their charter through *quo warranto* proceedings).

49. As discussed previously, the opposite treatment would automatically allow most U.S. healthcare establishments to avoid antitrust regulations. *See supra* note 47. There is disagreement between legal experts regarding the adequacy of this approach, which is represented primarily by Richard Posner and William Lynk. Compare Tomas J. Philipson & Richard A. Posner, *Antitrust in the Not-for-Profit Sector*, 52 J.L. & ECON. 1, 2 (2009) (supporting the treatment of non-profit establishments similarly to for-profits), with William J. Lynk, *Nonprofit Hospital Mergers and the Exercise of Market Power*, 38 J.L. & ECON. 437, 459 (1995) (suggesting exclusion of non-profits from traditional antitrust rules mostly due to their inability to fix higher prices). However, Lynk’s view is considered outdated based on the government agencies’ treatment of the issue, which stipulates that non-profit hospitals with more market power set higher prices with all other factors being equal. JOHN SIMPSON & RICHARD SHIN, DO NONPROFIT HOSPITALS EXERCISE MARKET POWER? 16 (1996).

50. *See* Clayton Antitrust Act of 1914, Pub. L. No. 63-212, § 7, 38 Stat. 730, 731 (codified as amended at 15 U.S.C. § 18 (2018)).

51. The Sherman Act explicitly prohibits “contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce.” 15 U.S.C. at § 1.

52. The “unreasonable” requisite as applied to such restraint was adopted in the *Standard Oil* case in 1911, over two decades after the passage of the Sherman Act. *Standard Oil Co. v. United States*, 221 U.S. 1, 87–88 (1911) (emphasis omitted).

53. Robin E. Remis, *Healthcare and the Federal Antitrust Laws: The Likelihood of a Harmonious Coexistence*, 13 J. CONTEMP. HEALTH L. & POL’Y 113, 117 (1997) (quoting S. REP. NO. 63-698, at 1 (1914)).

expand on, however, the Clayton Act carries no criminal penalties.⁵⁴ Section 7 of the Clayton Act is arguably its most important provision; it prohibits mergers that would “lessen competition, or tend to create a monopoly.”⁵⁵

The Clayton Act was amended by the Robinson–Patman Antidiscrimination Act of 1936 (Robinson–Patman Act)⁵⁶ and by the Hart–Scott–Rodino Act of 1976 (Hart–Scott–Rodino Act).⁵⁷ The Robinson–Patman Act “bans certain discriminatory prices, services, and allowances in dealings between merchants.”⁵⁸ The Hart–Scott–Rodino Act, also known as the Antitrust Improvements Act of 1976, requires parties to notify federal antitrust agencies about intended consolidations exceeding the specified dollar threshold.⁵⁹ This requirement strengthened the incipency provision of the Clayton Act by allowing the agencies to investigate proposed transactions

54. A Clayton Act violation carries only a civil penalty of up to \$5,000 per violation. 15 U.S.C. § 21(*l*).

55. *Id.* § 18. Under the Clayton Act, antitrust considerations are “not merely an appraisal of immediate impact of the merger upon competition, but prediction of its impact upon competitive conditions in the future.” *United States v. Phila. Nat’l Bank*, 374 U.S. 321, 362 (1963). It is essentially a reasonableness check on whether competition will be lessened and, therefore, it must be predictable enough to serve for “sound business planning.” *Id.* Consequentially, § 7 of the Clayton Act protects healthy competition from the possibility that some companies would entertain a merger only to increase their market power. *Id.*

56. Robinson–Patman Antidiscrimination Act of 1936, Pub. L. No. 74-692, 49 Stat. 1526 (codified as amended at 15 U.S.C. § 13 (2019)).

57. The Hart–Scott–Rodino Antitrust Improvements Act of 1976, Pub. L. No. 94-435, 90 Stat. 1383 (codified as amended at 15 U.S.C. § 18(a) (2018)).

58. *The Antitrust Laws*, *supra* note 37.

59. 15 U.S.C. § 18(a). When the Hart–Scott–Rodino Act passed in 1976, the minimum dollar threshold—*size of transaction*—for preliminary reporting was \$50 million; it is adjusted annually and was \$80.8 million in 2017. Premerger Notification Office Staff, Bureau of Competition, *HSR Threshold Adjustments and Reportability for 2017*, FED. TRADE COMMISSION (Feb. 7, 2017, 9:31 AM), <https://www.ftc.gov/news-events/blogs/competition-matters/2017/02/hsr-threshold-adjustments-reportability-2017> [<https://perma.cc/NR9W-2QGS>] (addressing “as adjusted” threshold amounts and confirming the annual adjustment). The value of transactions in healthcare is oftentimes more modest. In the second quarter of 2017, for example, total deal value was \$49.6 billion—219 deals total—but \$43.3 billion of it was attributed to only ten mega-deals exceeding \$1 billion each. NICK DONKAR, PWC DEALS: US HEALTH SERVICES DEALS INSIGHTS Q2 2017, at 1–2 (2017), <http://www.pwc.com/us/en/health-industries/publications/assets/pwc-health-services-deals-insights-q2-2017.pdf> [<https://perma.cc/7J7P-4584>]. Simple math shows that the average value of the remaining 209 deals is *only* \$30 million, which is below the reportability threshold. *See id.*

pre-consummation.⁶⁰ However, exceptions do apply, and many healthcare transactions do not meet the threshold by default.⁶¹

The McCarran–Fergusson Act of 1945 (McCarran–Fergusson Act) created another exception that explicitly exempted the “business of insurance” from some federal antitrust laws.⁶² Specifically, that meant the states were empowered to regulate insurance companies as they deem fit provided (1) the insurance companies act in their capacity of the “business of insurance,” (2) the business falls under the regulation by state law, and (3) the challenged activity does not constitute “boycott, coercion, or intimidation.”⁶³ The McCarran–Fergusson Act does not define the “business of insurance,” which has left the courts to interpret it to (1) “involve[] the underwriting or spreading of risk,” (2) encompass “insurer–insured relationship,” and (3) be limited to activities of the “entities within the insurance industry.”⁶⁴ The McCarran–Fergusson Act apparently does not prevent federal agencies from challenging health insurance mergers as demonstrated by the scrutiny applied to the Anthem/Cigna and Aetna/Humana proposed mergers in 2016.⁶⁵

The Competitive Health Insurance Reform Act of 2017 is pending legislature aimed at repealing the “business of insurance” federal exemption.⁶⁶ The scope of this Comment excludes analysis of the proposed legislation and

60. See 15 U.S.C. § 18(a).

61. See DONKAR, *supra* note 59, at 2 (discussing transaction size). Additionally, “acquisitions . . . in the ordinary course of business are exempt.” 16 C.F.R. § 802.1 (2012).

62. McCarran–Fergusson Act of 1945, ch. 20, § 1, 59 Stat. 33 (codified as amended at 15 U.S.C. § 1011 (2018)).

63. 15 U.S.C. at §§ 1011–13.

64. Alan M. Anderson, *Insurance and Antitrust Law: the McCarran–Ferguson Act and Beyond*, 25 WM. & MARY L. REV. 81, 90 (1983) (citing *Grp. Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) and *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982)).

65. These two cases were widely discussed in the healthcare field. The size of the merger was unprecedented and the timing of the two transactions came very close to each other. In September 2015, the DOJ started proceedings challenging the horizontal merger between Anthem and Cigna, which was enjoined in April 2017. See *United States v. Anthem, Inc.*, 855 F.3d 345 (D.C. Cir. 2017). In July 2016, the DOJ opened the case challenging the horizontal merger of Aetna and Humana, which was resolved in January 2017 by prohibiting the merger to proceed. See *United States v. Aetna, Inc.*, 240 F. Supp. 3d 1 (D.C. Cir. 2017).

66. Competitive Health Insurance Reform Act of 2017, H.R. 372, 115th Cong. (2017). The Act—which was passed in early 2017 by the House of Representatives and is currently under review of the Senate’s Committee on the Judiciary—is meant to repeal the McCarran–Ferguson antitrust exemptions for health insurance companies but keeps it intact for other insurance companies, such as auto and property. See *H.R.372–Competitive Health Insurance Reform Act of 2017*, CONGRESS.GOV, <https://www.congress.gov/bill/115th-congress/house-bill/372> [<https://perma.cc/6HWQ-ZXQH>]. The justification for the repeal is the national nature of health insurance companies. See *H.R. 372: Competitive Health Insurance Reform Act of 2017*, GOVTRACK (May 25, 2017), <https://www.govtrack.us/congress/bills/115/hr372/summary> [<https://perma.cc/JES5-P58Z>].

its impact; however, the initial success of the repeal efforts presumably evidences the changing view to insurance companies. Pending removal of the state exemption indicates insurers are perceived as operating on the national scale with the presumption that state antitrust laws no longer adequately protect against antitrust violations.⁶⁷ One of the main arguments used by proponents of the repeal is the highly-concentrated nature of the healthcare market and barriers to entry that require “a high standard of uniform [federal] protection” instead of being regulated solely on the state level.⁶⁸

Federal antitrust laws, in summary, prohibit restraint of trade and have protection of competition and of consumer welfare as their ultimate purpose.⁶⁹ The major federal antitrust provisions, overall, are “broad and ambiguous in language [and, in essence, are] the skeleton to which the courts have added the meat.”⁷⁰ Federal antitrust laws can be relatively easily applied to horizontal transactions, as supported by the long history of judicial interpretation. Yale economist, Fiona Scott Morton, said: “When a competition problem

67. There were unsuccessful efforts to repeal the McCarran-Ferguson antitrust exemption in the past. *See* Insurance Competitive Pricing Act of 1994, H.R. 9, 103d Cong.; *see also* Competitive Health Insurance Reform Act of 2015, H.R. 494, 114th Cong. (amending the McCarran-Ferguson Act to declare that nothing in that Act modifies, impairs, or supersedes the operation of antitrust laws with respect to the business of health insurance, including dental insurance); Health Insurance Industry Antitrust Enforcement Act of 2015, H.R. 99, 114th Cong. (prohibiting the McCarran-Ferguson Act from being construed to permit health insurance or medical malpractice insurance issuers to engage in price fixing, bid rigging, or market allocations in connection with providing health insurance or medical malpractice coverage).

68. *Competitive Health Insurance Reform Act of 2017: Hearing on H.R. 372 Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the H. Comm. on the Judiciary*, 115th Cong. 2 (2017) (prepared statement of David Balto, Principal, David A. Balto Law Offices). The repeal, therefore, serves the purpose of uniform federal regulation in insurance regulations, considering the fact that many insurance companies operate across state lines. *See* Richard Cauchi, *Allowing Purchases of Out-of-State Health Insurance*, NCSL (June 1, 2018), <http://www.ncsl.org/research/health/out-of-state-health-insurance-purchases.aspx> [https://perma.cc/ZN7T-HZLJ]. Proponents of having “business of insurance” exception intact argue that only the ultimate repeal of the McCarran-Ferguson Act would allow complete federal regulation. *See, e.g.,* Morgan Lee, *The Implied Antitrust Immunity Analysis of Credit Suisse v. Billing: A Framework Congress Should Apply to McCarran-Ferguson Act Repeal Efforts*, 2015 COLUM. BUS. L. REV. 349, 388 (2015).

69. RICHARD A. POSNER, *ANTITRUST LAW: AN ECONOMIC PERSPECTIVE*, at ix (1976) (“[T]he only goal of the antitrust laws should be to promote economic welfare . . .”); *see also* BORK, *supra* note 18.

70. JOHN J. MILES, *ANTITRUST FUNDAMENTALS* 6 (1999), Westlaw AHLA-PAPERS P10049905.

arises, it has to fit into the laws we have: the Sherman Act and the Clayton Act . . . [a]nd how you interpret those into the modern economy takes a little bit of skill.”⁷¹ Courts are not the only interpreters of antitrust laws; the first stab at the interpretation is usually taken by those who are put in the position to enforce these laws.⁷²

B. *The Enforcers of the Antitrust Laws and Regulatory Framework*

Two separate government agencies, the FTC⁷³ and the Antitrust Division of the DOJ,⁷⁴ enforce federal antitrust laws.⁷⁵ Their authority in some instances is shared and in other instances is exclusive to a single agency.⁷⁶ For

71. Morton, *supra* note 5.

72. The McCarran–Fergusson Act partially explains why every state has its own antitrust laws by stating the antitrust laws “shall be applicable to the business of insurance to the extent that such business is not regulated by State law.” 15 U.S.C. § 1012 (2018). Pennsylvania is the only state without state antitrust legislature. 1 JOHN J. MILES, HEALTH CARE AND ANTITRUST LAW § 1.3 (2018). State laws may not significantly differ from federal antitrust laws; in California, for example, the Cartwright Act, which passed in 1907—earlier than some of the federal antitrust statutes—prohibits restraints on trade and commerce. LAURIE L. LEVENSON & ALEX RICCIARDULLI, THE RUTTER GROUP—CALIFORNIA CRIMINAL LAW § 9:36 (2017–2018 ed. 2017). California antitrust laws are enforced by the California Attorney General and the district attorneys. CARLTON A. VARNER & THOMAS D. NEVINS, CALIFORNIA ANTITRUST AND UNFAIR COMPETITION LAW 2 (3d ed. 2003). The violation may result in criminal penalties—fines of up to \$1 million for corporations and \$250,000 for individuals along with a possibility of imprisonment of up to three years—or civil penalties—\$2,500 per violation. *Id.*

73. The FTC has five Commissioners, appointed by the President for the term of seven years. 15 U.S.C. § 41 (2018). The FTC is comprised of three Bureaus: the Bureau of Competition, which “seeks to prevent anticompetitive mergers and other anticompetitive business practices in the marketplace”; the Bureau of Consumer Protection, which “protect[s] consumers against unfair, deceptive or fraudulent practices”; and the Bureau of Economics, which “helps the FTC evaluate the economic impact of its actions.” *Bureaus & Offices*, FED. TRADE COMMISSION, <https://www.ftc.gov/about-ftc/bureaus-offices> [<https://perma.cc/UEN6-MKQK>].

74. The DOJ is a division of the Office of the U.S. Attorney General, which is led by the Assistant Attorney General and is comprised of Civil, Criminal, and Economic Sections. *Sections and Offices*, U.S. DEPT. JUST. (Feb. 9, 2018), <https://www.justice.gov/atr/sections-and-offices> [<https://perma.cc/D4JJ-8GPK>].

75. *Enforcement*, FED. TRADE COMMISSION, <https://www.ftc.gov/enforcement> [<https://perma.cc/UH2C-PCY6>]; *Mission*, U.S. DEPT. JUST. (July 20, 2015), <https://www.justice.gov/atr/mision> [<https://perma.cc/4GVC-7D88>]. Together, the agencies are protecting the three pillars of antitrust: consumer choice, innovation, and free competition. *See id.* For a more detailed discussion of the differences between the two agencies, see Todd N. Hutchison, *Understanding the Differences Between the DOJ and the FTC*, ABA, https://www.americanbar.org/groups/young_lawyers/publications/the_101_201_practice_series/understanding_differences.html [<https://perma.cc/9YN3-8Y4A>].

76. *See* 15 U.S.C. § 21 (2018) (establishing the FTC enforcement provisions); *id.* § 25 (providing the DOJ proceedings provision).

example, both agencies enforce Section 7 of the Clayton Act.⁷⁷ On the other hand, the DOJ enforces the Sherman Act,⁷⁸ while the FTC enforces the FTCA.⁷⁹ Historically, the “agencies complement each other [and develop] expertise in particular industries or markets.”⁸⁰ Following the *divide and conquer* approach, the FTC has become the leading agency on matters involving providers, and the DOJ has acted as the leading agency on matters involving insurers.⁸¹ Primarily, the two agencies ensure antitrust compliance of mergers and major developments in healthcare that have the potential to impact consumers and result in increased “market power,” or the ability to raise prices unilaterally.⁸²

Both agencies provided significant input in the area of healthcare antitrust regulation in the years immediately preceding or directly following the enactment of the ACA.⁸³ They view their role as “help[ing to] maintain competition in the healthcare financing and delivery markets, and ensur[ing] that market participants can compete to satisfy consumer demand.”⁸⁴ Importantly, the input by the agencies in the form of guidelines does not

77. *Id.* § 21(a); *id.* § 25.

78. *Id.* § 4.

79. *Id.* § 45. Although the FTC does not enforce the Sherman Act directly, it is charged with its indirect enforcement through the FTCA. *The Antitrust Laws*, *supra* note 37.

80. *The Antitrust Laws*, *supra* note 37.

81. See DOJ, FTC FOCUS ON BUSY HEALTHCARE DEALS LANDSCAPE (2016), <https://www.pwc.com/us/en/health-industries/health-research-institute/assets/pdf/pwc-hri-spotlight-doj-ftc-deals-activity.pdf> [<https://perma.cc/G86K-2X5C>].

82. The term “market power” is frequently used to describe the anticompetitive practice of price fixing and control market. Hammer & Sage, *supra* note 17, at 89. Some believe exercising “market power” is the “touchstone” in all antitrust cases. Sage et al., *supra* note 17, at 33.

83. Federal agencies are said to be “integral to advancing the [Obama] Administration’s healthcare reform goals.” MATTHEW L. CANTOR & MARLENE KOURY, A WATCHFUL ANTITRUST EYE IN HEALTHCARE 1 (2012) https://s3.amazonaws.com/ccannon/pdf/cantor_koury_healthcare_antitrust.pdf [<https://perma.cc/9FVY-43MQ>]. The FTC and the DOJ promoted the healthcare cost containment goal of the ACA by blocking mergers that had potential to increase prices and decrease competition. See *id.* at 1, 3 (referring to the FTC blocking the merger between Palmyra Park Hospital and Phoebe Putney Health Systems, as well as to the DOJ lawsuit against Blue Cross Blue Shield). Some actions by the FTC and the DOJ that indirectly promoted the purposes of the ACA include the revision of the *Horizontal Merger Guidelines*—latest revision in 2010, in the midst of the ACA passing—and the issuance of the *ACO Policy Statements*—latest revision in 2011, immediately after the ACA passing. See discussion *infra* Section II.C.

84. IMPROVING HEALTH CARE, *supra* note 30.

constitute binding legal authority, and therefore, is merely persuasive.⁸⁵ Still, the agencies provide guidance to healthcare organizations so that antitrust violations do not arise; they take a proactive rather than retroactive approach. The agencies first jointly issued the *Statements of Antitrust Enforcement Policy in Healthcare (Statements)* in 1993, amended them in 1994, and further revised in 1996; they have remained unchanged since.⁸⁶ The *Statements* explain the agencies' rationale in antitrust analysis and contain examples of its application, along with outlining "antitrust safety zones."⁸⁷ The "safety zones" mean that unless there are obvious violations, the FTC and the DOJ will not challenge the transaction.⁸⁸

Two other important documents, produced in collaborative effort by the FTC and the DOJ, are the *Horizontal Merger Guidelines*⁸⁹ and the *Non-Horizontal Merger Guidelines*,⁹⁰ which are often referred to as *Vertical Merger Guidelines*.⁹¹ Because they are not industry-specific, both documents provide standard frameworks that are applied generally.

The *Horizontal Merger Guidelines* were first issued in 1968 and have undergone periodic revisions, the latest occurring in 2010.⁹² Their purpose

85. The guidelines are the agencies' interpretation of the antitrust law. Courts often rely on them without being required to follow them. *See, e.g.,* Saint Alphonsus Med. Ctr.—Nampa Inc. v. St. Luke's Health Sys., Ltd., 778 F.3d 775, 784 n.9 (9th Cir. 2015) ("Although the Merger Guidelines are 'not binding on the courts' . . . they 'are often used as persuasive authority.'" (citations omitted)); *United States v. Kinder*, 64 F.3d 757, 771 (2d Cir. 1995) ("Although it is widely acknowledged that the Merger Guidelines do not bind the judiciary in determining whether to sanction a corporate merger or acquisition for anticompetitive effect . . . courts commonly cite them as a benchmark of legality." (citation omitted)).

86. *See* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE 1–2 (1996) [hereinafter THE STATEMENTS]. Since 1996, however, healthcare has changed dramatically: the ACA was introduced in 2010, and multiple other initiatives followed. *See generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. §§ 18001–18122 (2018)).

87. *Id.* at 5–7.

88. *Id.*

89. Statutory framework of the *Horizontal Merger Guidelines* includes § 7 of the Clayton Act, §§ 1 and 2 of the Sherman Act, and § 5 of the Federal Trade Commission Act. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES 1 (2010) [hereinafter HORIZONTAL MERGER GUIDELINES].

90. *See generally* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, NON-HORIZONTAL MERGER GUIDELINES (1984) [hereinafter NON-HORIZONTAL MERGER GUIDELINES].

91. *See generally, e.g.,* Steven C. Salop & Daniel P. Culley, *Revisiting the U.S. Vertical Merger Guidelines: Policy Issues and an Interim Guide for Practitioners*, 4 J. ANTITRUST ENFORCEMENT 1 (2016).

92. Revisions took place in 1982, 1984, 1992, 1997, and 2010. *20th Anniversary of the 1982 Merger Guidelines: The Contribution of the Merger Guidelines to the Evolution of Antitrust Doctrine*, U.S. DEP'T JUST. (July 22, 2015), <https://www.justice.gov/atr/hmerger> [<https://perma.cc/28CY-32BW>]. *See generally* HORIZONTAL MERGER GUIDELINES, *supra* note 89.

is to describe the “principal analytical techniques [and] practices”⁹³ that the agencies apply when analyzing horizontal mergers among competitors.⁹⁴ Relevant factors used by the agencies would include: relevant products, geographic markets, market participants’ identification and assessment, and methods to calculate market share and market concentration,⁹⁵ to name a few.⁹⁶ These guidelines also assess conduct besides mergers, such as entry barriers and efficiencies, and therefore, assist in assessing new player formation and coordinating care.⁹⁷

The *Vertical Merger Guidelines* were issued in 1984.⁹⁸ Antitrust experts assert they are overdue for an update.⁹⁹ They do not address healthcare specifically and are rarely referred to in court decisions.¹⁰⁰

After the enactment of the ACA, there was an increase in successful antitrust actions initiated by the agencies.¹⁰¹ The enforcers have taken the position

93. HORIZONTAL MERGER GUIDELINES, *supra* note 89.

94. Horizontal mergers involve conduct between firms at the same level of production. *Id.* In healthcare, it is equivalent to two hospitals merging. *Id.* In contrast, vertical mergers are between businesses at different levels of the same industry, such as a hospital acquisition of a health plan. *Id.*

95. A standard measure of market concentration is Herfindahl–Hirschman Index (HHI), which is calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. Proportionally greater weight is given to larger market shares. *Id.* at 18–19. Based on the HHI, markets are classified as unconcentrated, moderately concentrated, or highly concentrated. *Id.*

96. See DEBORAH L. FEINSTEIN, ANTITRUST ENFORCEMENT IN HEALTH CARE: PROSCRIPTION, NOT PRESCRIPTION 4 (2014), https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf [<https://perma.cc/AM6R-ANCN>]. These factors were relevant enough to be outlined by the director of FTC Bureau of Competition. *Id.*; see also HORIZONTAL MERGER GUIDELINES, *supra* note 89, at 3–6 (naming primary types and sources of evidence indicating anticompetitive effects of a merger, with market share and market concentration among those).

97. HORIZONTAL MERGER GUIDELINES, *supra* note 89, at 28.

98. NON-HORIZONTAL MERGER GUIDELINES, *supra* note 90, at 23.

99. Thomas L. Greaney & Douglas Ross, *Navigating Through the Fog of Vertical Merger Law: A Guide to Counselling Hospital-Physician Consolidation Under the Clayton Act*, 91 WASH. L.R. 199, 201 (2016); see also Salop & Culley, *supra* note 91, at 2 (describing the *Vertical Merger Guidelines* as “woefully out of date” due to the fact that they “do not reflect current economic thinking” and agency practices).

100. Overall, there are fewer vertical enforcement actions than horizontal enforcement actions: professors Salop and Culley have counted forty-eight vertical merger challenges between 1994 and 2015. Salop & Culley, *supra* note 91, at 3.

101. DAVID A. BALTO & JAMES KOVACS, CONSOLIDATION IN HEALTHCARE MARKETS: A REVIEW OF THE LITERATURE 2 (2013). Agencies acknowledge that they distinguish between *good* and *bad* collaborations and that antitrust enforcement is meant to separate them. See FEINSTEIN, *supra* note 96, at 2 (“In every investigation of health care provider transactions,

that the success of healthcare reform “depend[s] heavily on competition to control costs and improve quality.”¹⁰² However, the increased litigation has not yet touched upon the innovative vertical mergers and collaborations and has primarily challenged horizontal mergers.¹⁰³ Still, the increase in litigated matters evidences the growing concern of market concentration and the impact of the ACA-encouraged vertical integration.

In addition to these federal regulatory entities, state regulators and private suits¹⁰⁴ also may play a role in regulating antitrust activities in this context.¹⁰⁵ These areas of regulation, however, are outside the scope of this Comment.¹⁰⁶

we carefully consider evidence that the transaction will benefit consumers through improved quality, new services and/or decreased costs. We expect and encourage parties to provide us with concrete evidence to support their quality claims. We work closely with experts in the field to assess the arguments made by providers about improvements to quality of care.”).

102. Edith Ramirez, *Antitrust Enforcement in Health Care—Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245, 2245 (2014).

103. In the period from 2010 to 2015, only seven vertical mergers were challenged but none of them were in healthcare. Jaime Stilson, Partner, Dorsey & Whitney & Roger Feldman, Professor, Univ. of Minn., Lecture for the Minnesota State Bar Association: Vertical Mergers in Healthcare (Jan. 15, 2016).

104. Private plaintiffs are typically healthcare providers—that is, competitors, labor unions, and consumer groups. See ARTHUR N. LERNER, *MERGERS: ANTITRUST ISSUES FOR HOSPITALS AND HEALTH PLANS* 5 (2008), https://www.crowell.com/documents/Mergers_Antitrust-Issues-for-Hospitals-and-Health-Plans_Lerner.pdf [<https://perma.cc/T2KH-FEVN>]. It is noted that most private antitrust challenges are not successful: from 1985 to 1999, plaintiffs prevailed in only 14% of the cases, whereas defendants won 67% of cases. IMPROVING HEALTH CARE, 38 (citing Peter J. Hammer & William M. Sage, *Antitrust, Healthcare Quality, and the Courts*, 102 COLUM. L. REV. 545, 565 (2002)).

105. State attorneys general may also investigate merger activity in the health insurance industry. See 15 U.S.C. § 1012 (2018). State insurance departments must also review and approve proposed insurer and health maintenance organization mergers under state insurance holding company laws. See *About the NAIC*, NAIC, http://www.naic.org/index_about.htm [<https://perma.cc/TE7F-332Z>]. The role of state antitrust enforcement is viewed as complementary to the one of federal enforcement: the mission of federal and state antitrust law enforcement is “to protect the public from the harms flowing from anticompetitive conduct.” DIRECTORATE FOR FIN. & ENTER. AFFAIRS COMPETITION COMM., *RELATIONSHIP BETWEEN PUBLIC AND PRIVATE ANTITRUST ENFORCEMENT* 2 (2015), https://www.ftc.gov/system/files/attachments/us-submissions-oecd-other-international-competition-fora/publicprivate_united_states.pdf [<https://perma.cc/LCF6-RX3F>].

106. It is worth noting the existence of the doctrine of state action antitrust immunity, which is invoked when the questioned conduct arises from the state laws or regulations. *State Action Antitrust Immunity*, WEX, https://www.law.cornell.edu/wex/state_action_antitrust_immunity [<https://perma.cc/7PHV-J8AT>]. Under *Parker v. Brown*, a Supreme Court decision from 1943, state-authorized action is shielded from the federal antitrust laws. Shepard Goldfein & James A. Keyte, *Supreme Court Takes Case to Clarify State Action Immunity Doctrine*, N.Y.L.J., Apr. 8, 2014. To use the state action immunity, however, the state must be actively and closely monitoring the process. *Cal. Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980) (“[T]he challenged restraint must be ‘one clearly articulated and affirmatively expressed as state policy’ [and] the policy must be ‘actively supervised’ by the State itself.” (quoting *City of Lafayette v. La. Power & Light Co.*, 435 U.S. 389, 410 (1978))).

C. Agencies' Treatment of Accountable Care Organizations

The ACA brought into existence a brand-new healthcare structure: ACOs.¹⁰⁷ The growing number of ACOs were the primary driver for providing formalized guidance on how to treat the new collaboration structure under the federal antitrust laws published by the FTC and DOJ in 2011.¹⁰⁸ The *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program* (*ACO Statement*) addresses the process of the formal antitrust review of the ACO and potential antitrust concerns.¹⁰⁹ The *ACO Statement* has not been revised or expanded.¹¹⁰ A revision, however, is probably due because the *ACO Statement* was drafted in the early era of the ACO development, before the healthcare participants found themselves widely engaged in the ACO structure. The *ACO Statement* addresses the ACO phenomenon at its dawn, during the exploration stage.

The *ACO Statement* applies to providers eligible for participation in the Medicare Shared Savings Program.¹¹¹ Mergers are specifically excluded from coverage by the document and delegate merger evaluations to the *Horizontal Merger Guidelines*.¹¹² “Fully integrated entities” are also not subject to the *ACO Statement*’s guidance.¹¹³

107. Accountable Care Organizations are “integrated network[s] of doctors and hospitals that share[] financial and medical responsibility for providing coordinated care to patients with the intent of limiting unnecessary spending and improving care.” LISA SIMONSON MAIURO, ANTITRUST PRINCIPLES AND INTEGRATED HEALTH CARE: IMPLICATIONS FOR CONSUMERS AND HEALTH CARE ORGANIZATIONS 4 (2015); see also Jenny Gold, *Accountable Care Organizations, Explained*, KAISER HEALTH NEWS (Sept. 14, 2015), <https://khn.org/news/aco-accountable-care-organization-faq> [<https://perma.cc/UJF2-T32U>].

108. U.S. Dep’t of Justice & Fed. Trade Comm’n, *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, FED. REG., Oct. 28, 2011, at 67026 [hereinafter *ACO Statement*].

109. *Id.*

110. *See id.*

111. *Id.* at 67027. The Medicare Shared Savings Program is the original ACO model that now includes over 500 Shared Savings Program ACOs in fifty states and provides care to nine million Medicare beneficiaries. *About the Program*, CMS.GOV (Mar. 27, 2018, 11:54 AM), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/about.html> [<https://perma.cc/8MAK-X8AG>].

112. *ACO Statement*, *supra* note 108, at 67027.

113. *Id.* *Integration* is usually viewed as a system consisting of primary care providers, specialists, and hospitals—that is, a system capable of providing a full spectrum of services. Alain C. Enthoven, *What is an Integrated Health Care Financing and Delivery System (IDS)? and What Must Would-be IDS Accomplish to Become Competitive with Them?*,

Overall, federal antitrust laws establish a basic framework for all businesses, including the business of healthcare. Regulating agencies created additional guidelines to explain their interpretation of law and assist market participants. The regulations, however, do not adequately address the development of healthcare resulting from the adoption of the ACA. The existing framework is not expansive enough to address the issues specific to healthcare especially in the evolutionary period.

III. EXISTING REGULATIONS DO NOT ADEQUATELY REFLECT STRUCTURAL CHANGES

Existing regulations do not adequately reflect structural changes that healthcare has undergone in the past decade. “Coordinated care” has been the key trend of the decade but the term is not defined in the regulations. Intuitively, coordination in healthcare cannot avoid impacts to the industry because the balance between “restraint of trade” and “coordinated care” is shaky.

Current trends clearly demonstrate that, unlike in more traditional industries, in healthcare, especially today, there is a tight connection between value and compensation for services.¹¹⁴ The ACA creates financial incentives for consolidation among players in healthcare at the levels that seemed impossible pre-enactment of the ACA; providers, payers, and employers are collaborating to improve quality of care.¹¹⁵ As opposed to traditional industries, such as manufacturing or merchandise, where profit motive and lack of oversight drive consolidation strategy, integration in healthcare is implicitly encouraged—and, in all fairness, practically mandated to remain in the market—through payment reform initiatives such as bundled payments¹¹⁶ and development of ACOs. The increase in mergers is tremendous.¹¹⁷

HEALTH ECON. & OUTCOME RES., May 2016, at 1, 1. Recently, integration started to include health plans as well. *Id.* at 4–6.

114. The ACA has incentives for reducing costs and increasing quality of care, such as the Hospital Value-Based Purchasing Program. *See The Hospital Value-Based Purchasing (VBP) Program*, CMS.GOV (Aug. 2, 2018, 12:02 PM), <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing.html> [<https://perma.cc/KM28-7DFN>].

115. *See id.*

116. Bundled payment is a single payment for a “bundle” of related services during an episode of care rather than separate payments for each service. *See Patient Protection and Affordable Care Act*, Pub. L. No. 111-148, 124 Stat. 323 (2010) (codified as amended at 42 U.S.C. §§ 18001–18122 (2018)).

117. *See* Michael E. Martinez et al., *Antitrust Considerations Surrounding Health Care Consolidation Among Hospitals and Physicians*, K&L GATES (Aug. 19, 2014), <http://www.klgates.com/antitrust-considerations-surrounding-health-care-consolidation-among-hospitals-and-physicians-08-19-2014> [<https://perma.cc/AJ53-CH2U>] (citing *A Wave of Hospital Mergers*, N.Y. TIMES (Aug. 12, 2013), <https://archive.nytimes.com/www.nytimes.com/>

Most mergers subject the participating entities to often undesired attention from the antitrust regulators and certainly competitors who are assessing the impacts. The best way to avoid antitrust scrutiny, per the FTC, is not to merge.¹¹⁸ Industry players seem to despise this option; there is obvious growth of transactional activity, especially across providers of different types.¹¹⁹ Specifically, integration activity has been on the rise. Traditional alliances, such as joint ventures, medical foundation models, and management agreements with physicians, are supplemented with transactions that are reflective of the efforts to create care continuums.¹²⁰ Some call this trend the new rise of “managed care.”¹²¹

interactive/2013/08/13/business/A-Wave-of-Hospital-Mergers.html?_r=0) (noting that in 2009, before the ACA was enacted, there were fifty hospital acquisition deals and in 2012, there were 105); *see also* MARTIN GAYNOR ET AL., MAKING HEALTHCARE MARKETS WORK: COMPETITION POLICY FOR HEALTH CARE 7 (2017), <https://www.brookings.edu/wp-content/uploads/2017/04/gaynor-et-al-final-report-v11.pdf> [<https://perma.cc/TTV3-LJV7>] (“There were 1,412 hospital mergers from 1998 to 2015, with 561 of them from 2010–2015.”).

118. Martinez et al., *supra* note 117 (“What is the best way to avoid antitrust scrutiny, according to the FTC? Do not merge. Combinations that fall short of merger, such as joint ventures, and that provide for bona fide financial or clinical integration reasonably necessary to achieve consumer cost savings or improved care, may face less antitrust scrutiny.”).

119. Consolidation activity involving hospitals increased 18% from 2014 to 2015. Ayla Ellison, *The Rise of ‘Super Regional Systems’ and What it Means for Healthcare*, BECKER’S HOSP. REV. (Feb. 24, 2016), <https://www.beckershospitalreview.com/hospital-transactions-and-valuation/the-rise-of-super-regional-systems-and-what-it-means-for-healthcare.html> [<https://perma.cc/U6TV-65GA>]. 2016 continued the growth trend in the number of healthcare transactions. *See* John Meindl & Winston Smart, *VMG’s Healthcare Transactions and M&A Report: 2016 Trends and 2017 Expectations*, in AHLA 2017 HEALTH CARE TRANSACTIONS RESOURCE GUIDE at 37, 37–38 (2017), <https://vmghealth.com/wp-content/uploads/2018/01/VMG-Health-Transaction-Trends-2017.pdf> [<https://perma.cc/5SCT-TSEN>] (examining 2016 mergers and joint ventures across seven verticals in healthcare and estimating that growth trend will be sustained in 2017).

120. DaVita HealthCare Partners acquired physician group, The Everett Clinic, in 2016. Elizabeth Barker, *How Consolidation is Reshaping Healthcare*, HFMA LEADERSHIP (Apr. 20, 2017), http://www.hfma.org/Leadership/E-Bulletins/2017/April/How_Consolidation_Is_Reshaping_Health_Care/?trackref=auto. In 2011, the Mayo Clinic started Mayo Clinic Care Network, which offering telehealth partnerships. *Id.* This trend reflects what Kaufman Hall, one of the leading healthcare consulting firms, described as “not a positive or negative outcome [but] simply a reality that all organizations in the industry will have to undergo some level of collaboration.” *Id.*

121. The managed care model is a contract between health insurer and care provider for servicing a patient in exchange for fixed, or capitated, rate payments. *See* ERNST & YOUNG, MANAGED CARE 2.0: EVERYTHING OLD IS NEW AGAIN? 4 (2013), [https://webforms.ey.com/Publication/vwLUAssets/EY-managed-care-2-0-everything-old-is-new-again/\\$FILE/EY-managed-care-2-0-everything-old-is-new-again.pdf](https://webforms.ey.com/Publication/vwLUAssets/EY-managed-care-2-0-everything-old-is-new-again/$FILE/EY-managed-care-2-0-everything-old-is-new-again.pdf) [<https://perma.cc/67UG-RVLY>]. Traditional managed care is represented by health management organizations (HMOs) and

Federal authorities have also addressed the healthcare markets' consolidation mode. Former Secretary of the Department of Health and Human Services, Kathleen Sebelius, observed that "[t]here is a tight balance between a coordinated care strategy and a monopoly."¹²² Indeed, the ACA, by encouraging care coordination and integration, is in tension with antitrust laws.¹²³ However, federal antitrust regulations do not adequately reflect the changes the healthcare market is going through.

One of the new trends in healthcare structure is vertical integration, which the federal agencies recognized in the *vintage* 1984 guidelines.¹²⁴ Since that time, though, the healthcare landscape has changed significantly. Healthcare is moving from being a series of boutique shops to a one-stop center. To illustrate this, Harold Miller, president and CEO of the Center for Healthcare Quality & Payment Reform, compared modern patient-centered care to buying a TV: "A TV manufacturer like Sony may contract with many suppliers to build sets. Like Sony does for TVs, an ACO brings together the different component parts of care for the patient . . . and ensures that all of the 'parts work well together.'"¹²⁵

Vertical mergers today extend far beyond coordinating the activity of providers within the healthcare delivery system. The current trend embraces provider–payer consolidations that work to reduce competition from rivals not included in the network. It is well accepted in the industry and is now practically mandated by the ACA that the healthcare provider controls the patient.¹²⁶ The insurer, on the other hand, controls the patient through the plan, associated premiums, and deductibles. The question is whether, together, the provider and the insurer have the potential to control the market and even monopolize it by their collaboration.

Medicare Advantage plans, which require a beneficiary to select a primary care provider who coordinates their care and provides referrals for other services, including specialist care. *Id.* Essentially, the primary care provider serves as a gatekeeper in cost containment. Participation in an ACO, on the contrary, is non-binding for the beneficiary; even though alignment to a primary care provider is the corner stone of care coordination, there is no lock-in and the beneficiary free to seek care elsewhere. *Id.* at 1–3; Jason Shafrin, *What's the Difference Between an ACO and Managed Care*, HEALTHCARE ECONOMIST (Aug. 22, 2011), <http://healthcare-economist.com/2011/08/22/whats-the-difference-between-an-aco-and-managed-care> [<https://perma.cc/5RAL-KVBC>].

122. David Balto, *Antitrust: The Problem and Solution for Health Care*, U.S. NEWS (Apr. 12, 2013, 4:15 PM), <https://www.usnews.com/opinion/blogs/economic-intelligence/2013/04/12/after-affordable-care-act-new-antitrust-laws-needed-in-health-care>.

123. *Id.*

124. NON-HORIZONTAL MERGER GUIDELINES, *supra* note 90, at 29.

125. Gold, *supra* note 107.

126. ACO is the perfect example of such control over the patient. *See infra* Section III.C.3.

A. New Players in Healthcare Can Avoid Antitrust Scrutiny

To better understand the significance of antitrust implications for the healthcare landscape, familiarity with who actually comprises the business of healthcare as it currently stands is essential. This Comment intends to explore the “continuum of care” participants; therefore, it will concentrate on three major phenomena: (1) provider–payer as opposed to a standard health plan; (2) accountable care organizations; and (3) centralization of services for a patient.

1. Provider–Payer Structure is an Alternative to Traditional Health Plans

A “provider” is colloquially understood as a physician, although the regulations expand the definition.¹²⁷ In the current healthcare market, this concept must be broadened from an individual authorized to provide care and must include hospitals, physicians, and mid-level medical staff, or, in total, all players—care providers—in direct patient care.¹²⁸

Allowing healthcare providers to offer their own health plans is comparable to “let[ting] the foxes run the henhouse.”¹²⁹ Insurance companies have served as middlemen, but healthcare providers are starting to cut them out by taking on risk through entering the insurance market themselves, which arguably aligns the optimal treatment supplied by the clinicians with the cost cutting and tight controls incentivized by the insurance arm.¹³⁰ A number of traditional health systems now also offer their insurance plans, including Catholic Health Initiatives, Sharp HealthCare, Sutter Health, Geisinger Health,

127. See 29 C.F.R. § 825.125 (2017) (“[A healthcare provider is a] doctor of medicine or osteopathy who is authorized to practice medicine or surgery [as well as] nurse practitioners, nurse-midwives, clinical social workers and physician assistants . . .”).

128. Providers are further divided into primary, secondary, and tertiary—the difference being the levels of care corresponding to the patients’ needs. Kevin Grumbach & Thomas Bodenheimer, *The Organization of Health Care*, 273 JAMA 160, 160 (1995). In classical “managed care” primary care provider is in receipt of the capitated payment and are to optimize and minimize the amount of care received from secondary and tertiary providers. *Id.* at 161–62. In the population health model, the optimization is, in principle, the same with one exception: the primary provider is often part of the health system that includes secondary and tertiary providers, which means they are essentially employees of the same company. *Id.* at 165–66.

129. STEVEN BRILL, *AMERICA’S BITTER PILL* 431 (2015).

130. *Id.* at 432.

Ascension Health, and Partners Health.¹³¹ Providers are forced to provide value care rather than volume of treatments, and insurance premiums serve as a steady additional source of revenue.¹³² More importantly, the organization gains market share through the insured population.¹³³ The dual role of provider and payer permits the health system to fully own the patient data along with the information on treatment costs, thus enabling tighter control over care and cost management, which is a cornerstone in the world of bundled payments and “pay-for-performance.”¹³⁴

Today nearly 52% of insurance products are currently represented through plans owned by health systems such as Kaiser, Providence, Geisinger, and Inova.¹³⁵ Many of these payer-plans are multi-state entities; therefore, federal antitrust regulation is more appropriate than the state “business of insurance.”¹³⁶ In addition to the jurisdictional issues, the nature of the arrangement creates confusion over the identity of the lead antitrust enforcement agency, namely, whether the DOJ or FTC shall oversee assessment of the arrangement.¹³⁷

Kaiser is not a new model¹³⁸ but although it was previously an outlier in the FFS world, now, in the Value Based Purchase (VBP) care environment,

131. Ken Perez, *Healthcare Providers as Payers Too: Not So Wild an Idea*, HFM BLOG (May 9, 2016), <https://www.hfma.org/Content.aspx?id=48022>. The Advisory Board conducted a survey of over 100 hospitals and health systems; 34% of respondents already owned health plans and 21% were going to start a plan within the next five years. *Id.*

132. *Id.*

133. *Id.*

134. In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) was passed; it shifts physician reimbursement to VBP alternative payment models along with proposed physician fee bonuses for quality and for participation in the alternative payment models. See Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 101, 129 Stat. 87, 92–93. If a physician is not participating in any alternative payment models, his reimbursement is adjusted to a merit-based fee schedule accounting for quality measures, use of resources, and implementation of electronic health records. See *id.*

135. Susan Morse, *25 Biggest Provider-Sponsored Health Plans Include Some of the Nation’s Biggest Systems*, HEALTHCARE FIN. (Sept. 13, 2016), <https://www.healthcarefinancenews.com/news/25-biggest-provider-sponsored-health-plans-include-some-nations-biggest-systems> [<https://perma.cc/SD33-GN5G>]; see also Bob Herman, *More Health Systems Launch Insurance Plans Despite Caveats*, MOD. HEALTHCARE (Apr. 4, 2015), <http://www.modernhealthcare.com/article/20150404/MAGAZINE/304049981> [<https://perma.cc/W4NB-EPTN>].

136. The McCarran–Ferguson Act provides that the regulation of insurance is within the states’ authority. 15 U.S.C. §§ 1011–15 (2018). The Health Maintenance Organization Act delegates the regulation of HMO’s to the states. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (codified as amended at 42 U.S.C. § 300e (2018)). But the FTC and DOJ are both *federal* agencies, thus the controversy arises whether the state immunity would apply or whether the agencies should still oversee the providers.

137. See *supra* text accompanying note 76.

138. See *About Kaiser Permanente*, KAISER PERMANENTE, <https://share.kaiserpermanente.org/about-us/about-kaiser-permanente/> [<https://perma.cc/4LVK-2WY3>]. Kaiser’s model

it is becoming a new standard for cost efficiency.¹³⁹ Health systems form partnerships between healthcare providers and health plans. For example, in 2014, Anthem Blue Cross Vivity was created as a partnership in Southern California between Anthem Blue Cross and seven hospital groups in Los Angeles and Orange counties.¹⁴⁰ Together, the partners share in the profits and losses, so the basis of the arrangement is collaboration in care and financial decisions.¹⁴¹ This author was unable to find a record of whether the Vivity partnership came under the antitrust enforcement radar, but such a deal certainly has the potential to raise concerns, as it probably should.¹⁴²

is peculiar because a payer employs its own network of physicians and thus has exclusive control over the patient and maximum care coordination. See JESSE PINES ET AL., KAISER PERMANENTE—CALIFORNIA: A MODEL FOR INTEGRATED CARE FOR THE ILL AND INJURED 3–4 (2015), https://www.brookings.edu/wp-content/uploads/2016/07/KaiserFormatted_150504RH-with-image.pdf [<https://perma.cc/HY2H-JSPD>]. Kaiser owns hospitals and physician offices and offers a wide range of services practically eliminating the need to seek services out of the Kaiser network. *Id.* Despite the seeming integration, Kaiser is a fragmented system: it comprises separate entities—Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and Permanente Medical Groups—that contract exclusively with each other and share risk. *Id.*

139. At *The Atlantic*'s Healthcare Forum in 2014, it was observed that “Kaiserification” of the healthcare system is currently happening through consolidation of health insurance companies and healthcare providers, or “integrating insurance with delivery function.” Rob Garver, *Hospitals Plot the End of Insurance Companies*, FISCAL TIMES (Mar. 27, 2014), <http://www.thefiscaltimes.com/Articles/2014/03/27/Hospitals-Plot-End-Insurance-Companies> (quoting Dr. Ezekiel Emanuel, chairman of the Department of Medical Ethics and Health Policy at the University of Pennsylvania).

140. *Anthem Blue Cross Partners with Seven LA & Orange County Health Systems to Launch Vivity*, ANTHEM BLUECROSS (Sept. 17, 2014) [hereinafter *Anthem Blue Cross Partners*], <https://www.anthem.com/ca/press/california/anthem-blue-cross-partners-with-seven-la-amp-orange-county-health-systems-to-launch-vivity/> [<https://perma.cc/QE92-FE38>].

141. *Id.* (referring to the collaboration as “the trend of moving toward a structure that financially rewards activities to keep patients healthy”); see also *One Year Later, How is Vivity Stacking up to Kaiser? Checking in with MemorialCare CEO Dr. Barry Arbuckle*, BECKER'S HOSP. CFO REP. (Aug. 20, 2015), <https://www.beckershospitalreview.com/finance/one-year-later-how-is-vivity-stacking-up-to-kaiser-checking-in-with-memorialcare-ceo-dr-barry-arbuckle.html> [<https://perma.cc/4LVK-2WY3>] (stating that the goal of Vivity is “sharing the risk . . . [while] aligning the incentive to collaborate with one another”).

142. “As health insurance companies and health care providers increasingly enter each other's territories and the lines between their conventional business models begin to blur, competition will eventually undermine those who adhere to the old, inflexible regime.” David C. Szostak, *Vertical Integration in Health Care: The Regulatory Landscape*, 17 DEPAUL J. HEALTH CARE L. 65, 72 (2015). The question is whether this is a natural process of eliminating the old-fashioned and inflexible players or whether that is more of monopolizing the market and infringement of free competition. Based on the approach, novel partnership structures are worthy of a deep antitrust review.

The DOJ examined the Highmark and West Penn Allegheny Health System (WPAHS) affiliation and allowed the participants to proceed, this being one of the few affiliations that was actually examined.¹⁴³ Highmark is the Pennsylvania region's dominant health insurance company, a Blue Cross/Blue Shield licensee, and WPAHS is a hospital network; the DOJ called this affiliation agreement "a vertical combination [that] can reduce competition by limiting entry or expansion by third parties."¹⁴⁴ The challenge to the vertical merger did not stand the scrutiny. This Comment further analyzes the transaction in Part III.

Another of the few publicly known challenges to vertical integration, although not resulting in a judgment, was *Omni Healthcare*.¹⁴⁵ The issued opinion, however, addressed the question of whether vertical transactions can violate antitrust laws and held that arrangements between insurers and hospitals are prohibited as a matter of law.¹⁴⁶ Omni Healthcare sued Health First for violations of the Sherman Act and the Clayton Act.¹⁴⁷ Health First was the market leader in its region's inpatient hospital services with 86.8% market share; it operated physician practices and offered a range of health insurance plans through its insurance arm.¹⁴⁸ Omni alleged that Health First required its in-network providers to refer patients only within the Health First system.¹⁴⁹ Omni also alleged that Health First engaged in market monopolization by refusing to contract for inpatient hospital services with insurers other than Health First.¹⁵⁰ The court denied summary judgement finding there was a triable issue of fact and that a joint venture between a hospital and an insurer can violate § 1 of the Sherman Act if exclusive

143. *Statement of the Department of Justice's Antitrust Division on Its Decision to Close Its Investigation of Highmark's Affiliation Agreement with West Penn Allegheny Health System*, U.S. DEP'T JUST. (Apr. 10, 2012) [hereinafter *DOJ Statement*] <https://www.justice.gov/opa/pr/statement-department-justice-s-antitrust-division-its-decision-close-its-investigation> [<https://perma.cc/6A4G-CYBV>].

144. *Id.*

145. *Omni Healthcare, Inc. v. Health First, Inc.*, No. 6:13-cv-1509-Orl-37DAB, 2016 WL 4272164 (M.D. Fla. Aug. 13, 2016). This case became the basis of an article on provider–payer vertical integration that discussed issues peculiar to managed care, which, however, can be extended to post-enactment of the ACA period, integrated healthcare in general. *See generally* BRIAN J. MILLER & GEORGE L. WOLFE, *MANAGED CARE MARKETPLACE: GROWING DRIVERS OF PAYER-PROVIDER VERTICAL INTEGRATION* (2017) (analyzing vertical integration models through the *Omni Healthcare* decision).

146. *Omni Healthcare*, 2016 WL 4272164, at *16.

147. *Id.* at *11, *13.

148. *Id.* at *14.

149. *Id.* at *3, *13.

150. *Id.* at *3. The claim was specific to Medicare Advantage market, but it raises an important issue: can a hospital system exclusively contract with one insurer that it happens to own? *See* MILLER & WOLFE, *supra* note 145, at 3.

dealing is established.¹⁵¹ The case settled,¹⁵² and the court did not proceed with the analysis of vertical integration.¹⁵³ Health First, however, alluded to any growth being “a consequence of a superior product, business acumen, or historic accident.”¹⁵⁴ It would have been extremely interesting to see the case tried because it would present a concrete challenge to vertical integrations.

2. Accountable Care Organizations Promote Clinical Integration and Impede on the Traditional Antitrust Analysis

The ACA designed ACOs as a network of healthcare providers sharing financial and medical responsibility for patient care while striving to optimize treatment and eliminate unnecessary procedures and spending.¹⁵⁵ ACOs have a financial incentive to avoid unnecessary procedures because they are entitled to a portion of the savings as long as they meet quality targets.¹⁵⁶ The idea is to tie quality to value as well as to focus on preventive care and population management instead of FFS reimbursement.¹⁵⁷ The ACO structure implies alignment between payer and provider through management and administrative arrangements. It is a shared risk model, where provider commits to sharing costs for patient care above a specified benchmark.¹⁵⁸ Providers—physicians participating in an ACO, hospitals, home health agencies, that is, everyone providing services to the patient—continue to receive traditional payments from the payer, which is CMS in the original design, but will also receive a bonus payment if they perform at or above the specified quality

151. *Omni Healthcare*, 2016 WL 4272164, at *18.

152. Naeem S. Miller, *One Day into Trial, Health First Settles Case*, ORLANDO SENTINEL (Aug. 16, 2016, 5:25 PM), <http://www.orlandosentinel.com/health/os-health-first-settles-case-with-omni-20160816-story.html>.

153. *See generally Omni Healthcare*, 2016 WL 4272164.

154. *Id.* at *13 (quoting *Morris Commc'ns Corp. v. PGA Tour, Inc.*, 364 F.2d 1288, 1293–94 (11th Cir. 2004)). This allusion, which is typical in antitrust setting, serves as an example of reasons as to why antitrust cases present a challenge for the courts.

155. 42 U.S.C. § 1395jjj (2018) (“[ACO is] a shared savings program . . . that promotes accountability for a patient population and coordinates [services] for high quality and efficient service delivery.”); Gold, *supra* note 107 (“An ACO is a network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending.”).

156. Erwin A. Blackstone & Joseph P. Fuhr, *The Economics of Medicare Accountable Care Organizations*, 9 AM. HEALTH & DRUG BENEFITS 11, 12 (2016); *About the CMS Innovation Center*, CMS.GOV (May 29, 2018), <https://innovation.cms.gov/About/index.html> [<https://perma.cc/6XDT-5V73>].

157. *See* Gold, *supra* note 107.

158. *See id.*

standards and if the ACO's average per capita expenditures are lower than the benchmark.¹⁵⁹ If the average per capita expenditures exceed the benchmark, the ACO may be responsible for making a payment to CMS for their share of the loss.¹⁶⁰ In addition, the ACO will also bear the fixed cost of investments into the program: potentially a care management program, or investments into an electronic health records system, should it not be available originally.¹⁶¹

Obviously, for the ACO concept to work, healthcare providers must align their patient care efforts and have full access to the patient information. In the Medicare world, as CMS pioneered the ACO development,¹⁶² patients are not restricted to seeking care from a certain doctor, or even a specific network of doctors, and can opt out from data sharing.¹⁶³ Financial responsibility for the patient care, however, still remains with the ACO.¹⁶⁴ Along with the strict quality criteria, this differentiates ACOs from traditional health management organizations (HMOs).¹⁶⁵ Another important difference is that the ACO is a "health care provider-driven" organization, whereas the HMO is typically fronted by an insurer.¹⁶⁶

This Comment will discuss two broad categories of ACOs, Medicare and non-Medicare—or commercial. Although Medicare and commercial ACOs are quite similar in their concept, they must be treated separately, mostly due to the difference in payers and resulting differences in formation criteria as well as applicable antitrust analysis.

159. *About the CMS Innovation Center*, *supra* note 156.

160. *See Pioneer ACO Model*, CMS.GOV (Aug. 28, 2018), <https://innovation.cms.gov/initiatives/Pioneer-aco-model> [<https://perma.cc/3CQ8-VQM4>].

161. *See* Gold, *supra* note 107.

162. Currently, CMS offers multiple participating options for Medicare ACOs including the Medicare Shared Savings Program (MSSP)—which served as a prototype in the ACA and currently has three possible paths—the Pioneer ACO model, and the Next Generation ACO model. *Accountable Care Organizations (ACOs): General Information*, CMS.GOV (Aug. 31, 2018), <https://innovation.cms.gov/initiatives/ACO/> [<https://perma.cc/7F7W-U54D>]. The programs are similar in nature but differ in the specific ways of calculating benchmark and savings. *See id.*

163. *See generally* DEP'T HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., *THE PIONEER ACO MODEL: EXPERIENCE THROUGH A NEW MODEL OF CARE* (2011) [hereinafter *PIONEER ACO MODEL*]; FOUND. ACCOUNTABLE CARE NETWORK, *INFORMATIVE FAQs ON THE MEDICARE SHARED SAVINGS PROGRAM PROVIDED BY CMS*, <http://www.iefmc.org/Images/FACN%20ACO%20FAQs.pdf> [<https://perma.cc/9ALZ-Y9NX>].

164. *See* Gold, *supra* note 107.

165. The ACO model's underlying concept is value, whereas the HMO model has historically focused on financial aspects, often disregarding the quality element of providing care. *See* Shafrin, *supra* note 121.

166. DYLAN LANDERS-NELSON ET AL., *THE IMPACT OF ACCOUNTABLE CARE: EMPLOYER PERSPECTIVES ON ACCOUNTABLE CARE 4* (2015).

a. Medicare ACOs: Standard Model

Traditionally, ACOs are viewed as Medicare creatures. The “Shared Savings Program”—the underlying idea of the ACO—was established by the ACA¹⁶⁷ to promote accountability and care coordination for Medicare patient populations.¹⁶⁸ Section 3022 of the ACA provides that “groups of providers . . . meeting [specific] criteria . . . may work together [and are] eligible to receive payments for shared savings” as long as they “meet quality performance standards.”¹⁶⁹ Coordinated care intends to avoid duplication of services and prevent medical errors.¹⁷⁰

Medicare ACOs are powered by the Center for Medicare and Medicaid Services (CMS) and provide care to Medicare Part A and Part B patients; the Center for Medicare and Medicaid Innovation (CMMI) is the agency in charge of those innovative programs, which vary in risk sharing percentage and quality requirements.¹⁷¹ Participation in ACO models is “voluntary” for care providers.¹⁷² However, there obviously are incentives driving eligible providers to form ACOs. As of August 2017, there were 480 Medicare “ACOs serving over nine million beneficiaries” across the United States.¹⁷³

Medicare Advantage (MA) plans also participate in ACOs through network and access requirements that are controlling the market.¹⁷⁴ These trends are the *early birds* of private market concentrations, which are meant to

167. 42 U.S.C. § 1395jjj (2018).

168. Susan S. DeSanti, *ACO Antitrust Guidelines: Coordination Among Federal Agencies*, ANTITRUST SOURCE, Dec. 2011, at 1, 1.

169. 42 U.S.C. § 1395jjj.

170. *Accountable Care Organizations (ACOs)*, CMS.GOV (May 3, 2018, 2:52 PM), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/> [<https://perma.cc/F25M-CYX7>].

171. *See id.*

172. *Accountable Care Organizations (ACOs): General Information*, *supra* note 162.

173. Virgil Dickinson, *Medicare to Divulge when a Doc's Patient is in an ACO*, MOD. HEALTHCARE (Aug. 23, 2017), <http://www.modernhealthcare.com/article/20170823/NEWS/170829954> [<https://perma.cc/42ZN-HKW9>].

174. MA plans are offered by private insurance companies through their contracts with Medicare. *Different Types of Medicare Advantage Plans*, MEDICARE.GOV, <https://www.medicare.gov/sign-up-change-plans/medicare-health-plans/different-types-of-medicare-health-plans-.html> [<https://perma.cc/LU8E-ZFGH>]. The difference between the MA and ACO model is that MA beneficiaries—unlike ACO beneficiaries—choose to enroll and are not free to seek care elsewhere; MA, however, is value-based, similar to ACO. *Pioneer ACO Model Frequently Asked Questions*, CMS.GOV (Feb. 21, 2017), <https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/Pioneer-ACO-FAQs.html> [<https://perma.cc/8R7U-LF9H>].

shift risks and combine financial and economic elements of the care continuum. As of early 2015, 132 payers, including such notable commercial insurers as Aetna, Cigna, and UnitedHealth, had at least one accountable care contract.¹⁷⁵

To be eligible to participate in a Medicare ACO, an organization must meet certain criteria including ability to align the required number of beneficiaries, or patients, it is responsible for.¹⁷⁶ Again, the criteria are significantly easier to meet for larger systems.

b. Non-Medicare ACOs: Evolving Standard

Commercial, non-Medicare, ACOs are appealing to providers partially because non-government payers are significantly less rigid than CMS in financial risk-sharing arrangements and are more likely to account for the individual ACO's capacities in calculating quality metrics.¹⁷⁷ These ACOs are neither officially defined nor tracked,¹⁷⁸ and therefore, are not required to go through the same initial scrutiny as the Medicare ACOs. The process of commercial ACO development is significantly more efficient and fast, as federal regulations do not set entry barriers.¹⁷⁹

175. David Muhlestein, *Growth and Dispersion of Accountable Care Organizations in 2015*, HEALTH AFF. BLOG (Mar. 31, 2015), <http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/>.

176. The eligibility criteria will be discussed further in this Comment. *See infra* note 248. Meanwhile, it is enough to understand that the population alignment is based on strictly outpatient services and that the alignment is conducted through the participating physicians—that is, primary care providers. *See infra* note 248.

177. Robert Belfort, *Lowering Risk for Commercial ACOs*, H&HN (May 29, 2014), <http://www.hhnmag.com/articles/4184-lowering-risk-for-commercial-acos> [<https://perma.cc/DR8W-6793>]; *see also* Jesse Migneault, *Understanding the Basics of Accountable Care Organizations*, HEALTHPAYER INTELLIGENCE (May 23, 2017), <https://healthpayerintelligence.com/news/understanding-the-basics-of-accountable-care-organizations> [<https://perma.cc/PG44-7TV2>] (naming the following as three main reasons for the growing appeal of the commercial ACOs: an “opportunity to improve quality and efficiency, jumpstart population health improvement, and the acceptance that changes in medical payments are an inevitable part of the healthcare landscape”).

178. *Commercial Groups Driving Force Behind ACOs Development*, DEFINITIVE HEALTHCARE (Feb. 21, 2017), <https://www.definitivehc.com/news/commercial-groups-driving-force-behind-aco-development> [<https://perma.cc/Z9MC-EKCR>] (“Commercial ACOs cover millions of lives but are often overlooked because they have no public reporting requirements, their existence is not always announced, and rarely do providers or insurers give a complete account of their performance, unless one does especially well.”).

179. *See id.* (“According to a recent Leavitt Partners analysis, shared risk and shared savings agreements between providers and commercial insurers covered 17.2 million lives in April 2016, over twice as many as Medicare and Medicare ACOs combined. Definitive Healthcare currently counts over 500 commercial agreements, nearly 400 of which are directed by one of five major insurers.”).

ACOs represent a more recent trend ultimately being driven by large employers. Available ACO models of the kind may be created by the employer independently—“direct-to-employer” ACO—developed as a joint venture with an existing local ACO provider, or established as payer-directed; this model is most similar to a traditional self-funded insurance arrangement.¹⁸⁰ Under each model, employers may or may not share in the ACO’s savings—that is determined by the contractual arrangement, and obviously, the availability of accurate claims data will provide for establishing accurate benchmarks. Boeing¹⁸¹ and Qualcomm¹⁸² are among the many employers embarking on the ACO journey. There are multiple incentives for a large employer to become self-insured. Cutting the middleman is one, be it a third-party insurance administrator or an insurance company handling a close network for this employer. Direct-to-employer ACO is basically health insurance on steroids.

UnitedHealthcare, one of the leading health insurance carriers, launched its own ACO, NexusACO, on the national scale with participating providers from fifteen markets, including California.¹⁸³ NexusACO is made available to self-funded employers with over 100 employees.¹⁸⁴ That is highly reminiscent

180. MICHAEL T. SANDWITH, *THE ACO AND EMPLOYER OPPORTUNITIES: ACO SERIES PART 3*, at 3 (2011), https://www.healthstream.com/docs/default-source/master-document-repository/wp_it_theacoandemployeroportunities.pdf?sfvrsn=2 [<https://perma.cc/F7UV-7CC6>].

181. Boeing started offering their first ACO in 2014 and expanded the offerings to more areas since then; it employs more than 150,000 people across the United States. Marty Stempniak, *Will Boeing Change Health Care?*, H&HN (Dec. 10, 2015), <https://www.hhnmag.com/articles/6709-will-boeing-change-health-care> [<https://perma.cc/R3LP-J2XE>]. ACO options are currently available to 30,000 employees in the Puget Sound, 6,000 employees in South Carolina, 13,000 employees in St. Louis, and 15,000 employees in Southern California. Melanie Evans, *Boeing Negotiates Directly with More Health Systems*, MOD. HEALTHCARE (Aug. 4, 2015), <http://www.modernhealthcare.com/article/20150804/NEWS/150809961> [<https://perma.cc/XB7F-U9GN>]. Although Boeing has not publicly announced how many employees chose the ACO participation, the company stated it was more than expected. See Richard Stolz, *Boeing Expands its ACO Plan to Cover 15,000 Employees in Southern California*, EBN (July 11, 2016, 8:34 PM), <https://www.benefitnews.com/news/boeing-expands-its-aco-plan-to-cover-15-000-employees-in-southern-california> [<https://perma.cc/2VK8-689M>].

182. Qualcomm contracted with Scripps Health in San Diego to offer an ACO plan to over 12,000 local employees. Brad Graves, *Qualcomm First S.D. Firm to Contract with Scripps ACO*, SAN DIEGO BUS. J. (June 7, 2017), <https://www.sdbj.com/news/2017/jun/07/qualcomm-first-sd-firm-contract-scripps-aco/> [<https://perma.cc/E3ZN-LGU2>].

183. Bruce Japsen, *UnitedHealth Group Launches National ACO*, FORBES (Nov. 1, 2016, 8:00 AM), <https://www.forbes.com/sites/brucejapsen/2016/11/01/unitedhealth-group-launches-national-aco/#70aab3a74eca> [<https://perma.cc/7MD7-AJFU>].

184. *Id.* (reporting that more than twelve undisclosed employers have already signed up).

of a narrow-network plan, just with a different regulatory mechanism. The regulatory framework is not prepared to address the development of the ACO model into the commercial market. Current rules are tailored to a single-payer, non-negotiable environment.

*B. Application of Existing Antitrust Principles to the
New Models Lacks Clarity*

When the existing FTC and DOJ Statements of Antitrust Enforcement Policy in Healthcare were issued back in 1996, the then-FTC Commissioner stated that the guidelines “should reflect greater receptiveness to new and innovative forms of provider arrangements.”¹⁸⁵ The official guidelines provide a certain leeway for new developments in any industry, but do they adequately govern the changed healthcare landscape?

Traditionally, violations of antitrust law are analyzed either under the per se rule¹⁸⁶ or under the “rule of reason”.¹⁸⁷ The per se rule is especially

185. DAVID BALTO, MAKING HEALTH REFORM WORK 7 (2011), https://cdn.americanprogress.org/wp-content/uploads/issues/2011/02/pdf/aco_competition.pdf [<https://perma.cc/2VHQ-PPK7>] (quoting Christine Varney).

186. Per se illegality applies to “agreements or practices which . . . [have a] pernicious effect on competition and lack of any redeeming virtue” and therefore are unreasonable. *N. Pac. Ry. Co. v. United States*, 356 U.S. 1, 5 (1958). Per se rules are enforced in the uniform manner across all industries. Thomas A. Piraino, Jr., *Reconciling the Per Se and Rule of Reason Approaches to Antitrust Analysis*, 64 S. CAL. L. REV. 685, 720 (1991). The classic examples of per se offenses are price fixing between competitors—charging an agreed-upon amount for a service; boycotting—agreements not to deal with certain suppliers or customers, or market allocation—competitors dividing the market between themselves. Jeffrey L. Cohen, *How Antitrust Laws Hinder the Goals of Healthcare Reform*, MED. ECON. (May 10, 2012), <http://www.medicaleconomics.com/category-47287/how-antitrust-laws-hinder-goals-healthcare-reform> [<https://perma.cc/4VQU-2LXZ>]. The per se doctrine defines categories of business transactions that are illegal and present anticompetitive behavior which is outright prohibited; the caveat being that the “courts [are] careful not to adopt a per se approach until they ha[ve] gained enough experience to be confident that a particular restriction would have an anticompetitive impact in nearly all cases.” Piraino, *supra*, at 692. Per se rules are hardly applicable to the complex concept of care management which is highly specialized and unique to healthcare. As applied specifically to healthcare, per Deborah Feinstein, former FTC Commissioner, the following matters:

Does the proposed arrangement offer the potential for pro-consumer cost savings or quality improvements in the provision of healthcare services? Is there bona fide integration or is this simply a mechanism to enhance leverage with payers through joint negotiation? Even if there is bona fide integration, are any price or other agreements among participants regarding the terms on which they will deal with healthcare insurers reasonably necessary to achieve the benefits of the collaboration? If the answer to these questions is “yes,” then the collaboration is not considered a per se illegal agreement

FEINSTEIN, *supra* note 96, at 4.

187. Under rule of reason analysis, “the factfinder weighs all of the circumstances of a case in deciding whether a restrictive practice should be prohibited as imposing an unreasonable

important in working through price fixing schemes. In this case, the violation of law is so obvious that it is not necessary to weigh it against the potential benefits to the society and marketplace.¹⁸⁸ Currently, however, the rule of reason is becoming fundamental. Under this approach, the circumstances of the transaction or initiative must be carefully considered to interpret impacts to the competition.¹⁸⁹ Some agreements may be found valid under the rule of reason even if they are highly questionable under the per se rule.¹⁹⁰ Under the “rule of reason” analysis, courts first determine whether the structured deal has a measurable impact on competition and, if so, how it balances against the efficiencies created.

Even setting aside the novel character of the models under review, vertical mergers overall have not frequently been a subject of antitrust challenge.¹⁹¹ Partially, vertical integration and the concept of patient care continuum have been reflected in-managed care, also known as HMOs. However, HMO

restraint on competition.” *Cont’l T. V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 49 (1977). Because the language of the Sherman Act § 1 is extremely broad and prohibits “[e]very contract, combination . . . or conspiracy in restraint of trade,” it can easily be applied to literally any commercial transaction. 15 U.S.C. § 1 (2018). The rule of reason approach, therefore, has been applied to only challenge transactions where the restraint of trade is *unreasonable*. *Arizona v. Maricopa Cty. Med. Soc’y*, 457 U.S. 332, 343 (1982) (stating that since the *Standard Oil* decision, “most restraints” are analyzed under the rule of reason). The rule of reason balances the anticompetitive impacts of a transaction and the business benefits, thus determining the *reasonableness* of the transaction—obviously, *reasonable* transactions are not challenged. FEINSTEIN, *supra* note 96, at 4 (“Ultimately, [the FTC] make[s] a determination as to whether a particular agreement, on balance, benefits consumers or is likely to diminish quality, reduce output, or increase price.”).

188. One of the first cases to emphasize that antitrust laws applied unilaterally to healthcare was *Arizona v. Maricopa County Medical Society* where the Court determined that agreement amount physicians to set maximum prices was a per se violation of the Sherman Act. *Maricopa*, 457 U.S. at 361.

189. Similar to the totality of circumstances test, under the *rule of reason*, the overall competitive effect is analyzed by focusing on “the state of competition with, as compared to without, the relevant agreement.” U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS 4 (2000). Factors utilized in the analysis are flexible and may include business purpose, market, and independent competitive advantage. *See id.*

190. *Hearing*, *supra* note 21, at 6 (statement of Shari A. Pozen, Chief of Staff and Counsel to the Assistant Att’y Gen., Antitrust Division, U.S. Department of Justice) (asserting clinical integration “with its emphasis on realizing benefits for consumers—justifies rule-of-reason treatment for price setting or other agreements that might otherwise be per se illegal”).

191. *See generally* Jaime Stilson et al., *Reading the Tea Leaves: Evaluating Potential Antitrust Concerns in Vertical Mergers Between Insurers and Health Care Providers*, 30 ANTITRUST 11 (2015).

products received a reputation of cost-cutters and of trading quality for price.¹⁹² This is exactly what the new models are trying to avoid.

C. Providers May Have Anticompetitive Motives to Participate in an ACO Model

The influx of new ACOs in the market may evidence that they are becoming a vehicle for achieving efficiencies and a tool of “defensive consolidation in response to new payment models.”¹⁹³ Among the incentives determining why providers choose to participate in an ACO—either Medicare or private—the following are most commonly stated in varying interpretations: money, market expansion, and control over the patients—all of which have direct antitrust implications and concerns.

1. Money as an Incentive to Participate in an ACO

Discussing money is a faux pas in healthcare. However, in the *business of healthcare*, compensation and bottom-line keep the care industry afloat. Keeping costs low—the underlying goal of an ACO—can be achieved by incentivizing physicians to avoid unnecessary and duplicative services, such as hospitalizations, excessive tests, and procedures—as well as by utilizing cheaper providers. Usually, the primary concern of cost efficiency is sacrificing necessary services in the name of savings.¹⁹⁴ Another opportunity to keep costs low is the reduction in administrative costs through standardization and centralization of services that directly improve the operating margin. Lower expenditures provide an opportunity to keep prices low and indirectly eliminate or disfavor more expensive competitors. It is expensive to form and run an ACO, suggesting that larger organizations are better set up for entrance into the program; thus, mergers and consolidations are encouraged because organizations prefer to either have existing infrastructure for an ACO start-up or to absorb risks of ACO formation.¹⁹⁵

192. See Sage et al., *supra* note 17, at 39.

193. Hannah T. Neprash et al., *Little Evidence Exists to Support the Expectation that Providers Would Consolidate to Enter New Payment Models*, 36 HEALTH AFF. 346, 346 (2017).

194. This results in a bad reputation of HMO plans and traditional managed care. See *supra* note 121.

195. ACO start-up costs are estimated to be at least \$30 million in a midsize market. *Will ACO Show Financial Return?*, FIERCEHEALTHCARE (Jan. 23, 2012, 12:13 PM), <https://www.fiercehealthcare.com/healthcare/will-acos-show-financial-returns> [<https://perma.cc/Q9G9-BZL9>] (quoting Tom Scully, former CMS Administrator). CMS estimates the cost of operating an ACO at \$1.8 million in the first year; however, providers believe the true first-year operating costs exceed this estimate. Blackstone & Fuhr, *supra* note 156, at 13. Another estimate for start-up costs, coming from a healthcare consultant, is \$1,040 per aligned beneficiary—remember that an ACO must have a minimum of 5,000 beneficiaries to be

2. Market Expansion as an Incentive to Participate in an ACO

ACO market expansion is achieved through strategic partnerships. Partners share not only savings generated by the ACO, but also losses.¹⁹⁶ Thus, it is important to choose the right team to play on. The choice of not joining may pose a risk of being left out of the network that other providers form and the consequential loss of market share. In 2011, at the dawn of “the ACO era,” 8% of physicians either were already participating in an ACO or planned to join an ACO within a year.¹⁹⁷ Two years after, in 2013, the percentage tripled: 34% of physicians participating in the study were either in an ACO or planned to participate in one within a year.¹⁹⁸ California is a perfect example: it is home sixty-seven ACOs, more than any other state.¹⁹⁹ By 2022, 60% of the state population is expected to receive integrated care from an ACO provider.²⁰⁰ This trend could only mean that there is an incentive to consolidate and that single players are not expected to survive, at least easily.

3. Control Over the Patients as an Incentive to Participate in an ACO

ACO control over the patient usually implies control over the care continuum and sets the primary focus on providers being proactive in preventive services rather than treatments.²⁰¹ The control is moving from the insurance companies, with various incentives, to the providers.²⁰²

Another angle to look at, however, is control over patient care choices. ACOs are designed to maximize the quality of care without sacrificing the

eligible to participate. Howard Larkin, *ACO or No?*, H&HN (May 13, 2014), <http://www.hhnmag.com/articles/4208-aco-or-no>.

196. *Anthem Blue Cross Partners*, *supra* note 140.

197. Leslie Kane, *Physician Compensation: Doctors Adapting to a New Reality*, MEDSCAPE (Apr. 15, 2014), https://www.medscape.com/viewarticle/823435_2 [<https://perma.cc/5GEB-2GSH>].

198. *Id.*

199. BRENT D. FULTON ET AL., DRIVERS OF HEALTH EXPENDITURE GROWTH IN CALIFORNIA: FORECASTS AND PROGRESS ON DELIVERY SYSTEM INTEGRATION 14 (2014), http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/BerkeleyForum_ExpBrief2_2014dec1.pdf [<https://perma.cc/MDV7-BE6X>].

200. *Id.* at 13.

201. See OLIVER WYMAN, ACO UPDATE: ACCOUNTABLE CARE AT A TIPPING POINT 3 (2014).

202. See Blackstone & Fuhr, *supra* note 156, at 12 (providing that savings increase physicians’ “incentives for efficiency”).

patient's right to choose their care means.²⁰³ Although ACO-aligned patients are free to seek care elsewhere, the ACO is still responsible for the incurred costs.²⁰⁴ The ACOs still control the patient and are entitled to receive claims data unless the patient opts out of data sharing.²⁰⁵ Accordingly, ACO providers become informed about the competitors' prices and sometimes care levels and billing practices.²⁰⁶ ACOs may or may not use competitors' pricing to their advantage as a means of informing patients about treatment costs to influence their care choices.²⁰⁷ Price information may also be used as a tool to raise prices, along with the perceived market power ACOs have.²⁰⁸

D. Deficiencies of the Existing Regulations

There is little federal regulation over the transactions involving vertical mergers overall, especially with participation of insurance companies. Federal agencies admittedly recognize that integration of two companies at various spectrums of the industry chain is generally beneficial for consumers and results in major efficiencies.²⁰⁹ Although "some vertical mergers present competitive problems," the general view on vertical mergers is significantly more favorable than on horizontal mergers.²¹⁰

The discussion below is based on the nature of vertical integration and on its familiarity to the antitrust agencies due to its novice—or not so much—nature. On one side of the continuum are vertical mergers, which are the most customary, or traditional. Next is vertical integration that is newer and more difficult to analyze. The other side of the continuum includes ACOs that this Comment perceives as the grey area of vertical integration analysis.

203. The patient's absolute freedom to choose a care provider and seek services without a required referral is one of the primary features distinguishing an ACO from an HMO. *Id.* at 13.

204. *See id.* at 14.

205. PIONEER ACO MODEL, *supra* note 163, at 3–4.

206. Medicare ACOs receive claims data for all aligned beneficiaries monthly—regardless of where these claims are incurred, the only exception are alcohol and chemical dependency claims—and can perform extensive analysis not only on the services provided by the ACO network but also on services provided elsewhere. *Id.*

207. *See* Blackstone & Fuhr, *supra* note 156, at 13 (questioning whether lower costs would be a positive factor for the patient because often higher price serves as an indicator of higher quality).

208. *See id.*

209. The FTC has stated: "Vertical mergers can generate significant cost savings and improve coordination of manufacturing or distribution." *Competitive Effects*, FED. TRADE COMMISSION, <https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/mergers/competitive-effects> [<https://perma.cc/BJW6-6MG4>].

210. *Id.*

1. *Vertical Mergers: Expansion of the Classic Antitrust Challenge*

There is certain regulatory involvement in consolidation of existing companies positioned vertically—although different and probably less than in horizontal merger activities.²¹¹ The analysis starts with determining whether a dominant company is involved.²¹² The key question is how the federal regulators determine dominance in the market place, especially in the light of the changing healthcare landscape.

In scrutinizing the affiliation between Highmark—the Blue Cross affiliate operating in Pennsylvania—and WPAHS—a hospital system in Western Pennsylvania, the DOJ focused on the importance of the parties in Pennsylvania market.²¹³ Highmark is “the region’s dominant health insurance company” and “WPAHS is the second-largest hospital network in the Pittsburgh region.”²¹⁴ The analysis also emphasized potential for the parties’ collaboration with other players and looked at past experiences.²¹⁵ The DOJ allowed the transaction to proceed, but the key point is that their analysis was case-based and did not employ standard metrics. This is one of the challenges of vertical integration analysis. The parties are not directly competing with each other, but their integration may impact competitors in both markets.

The analysis in question also did not consider prior history of the participants. Two years prior to the vertical merger with Hallmark, WPAHS sued its major competitor in the Pittsburgh market, University of Pittsburgh Medical Center (UPMC), challenging its collaboration with Hallmark at the time and raising antitrust concerns.²¹⁶ WPAHS’s market share was slightly over 22% of the regional market, whereas UPMC was the market leader with

211. Aside from the number of vertical merger cases, vertical mergers involve firms that do not operate in the same market. It necessarily follows that such mergers produce no immediate change in the level of concentration in any relevant market . . . Although [vertical] mergers are less likely than horizontal mergers to create competitive problems, they are not invariably innocuous. NON-HORIZONTAL MERGER GUIDELINES, *supra* note 90, at 23.

212. ANTHONY SWISHER, VERTICAL INTEGRATION: DOES IT MATTER THAT IT’S HEALTHCARE? 2 (2016), https://www.americanbar.org/content/dam/aba/administrative/healthlaw/07_dominant_payer_dominant_provider.authcheckdam.pdf [<https://perma.cc/9CFQ-XDZ3>].

213. DOJ Statement, *supra* note 143.

214. *Id.*

215. *Id.*

216. W. Penn Allegheny Health Sys., Inc. v. UPMC, 627 F.3d 85, 93 (3d Cir. 2010) (citing Highmark, Inc. v. UPMC Health Plan, Inc., 276 F.3d 160, 171–73 (3d Cir. 2001)).

market share of around 55%.²¹⁷ Highmark and UPMC entered into an agreement to allegedly protect each other from competition, and the court found that the parties indeed engaged in uncompetitive behaviors that hurt WPAHS.²¹⁸

In 2014, Anthem Blue Cross announced a partnership with seven competing Los Angeles hospital groups, namely, “Cedars-Sinai, Good Samaritan Hospital, Huntington Memorial Hospital, MemorialCare Health System, PIH Health, Torrance Memorial Medical Center, and the UCLA Health System.”²¹⁹ This deal does not have expected integration between the hospital participants or between the insurer and the hospitals.²²⁰ However, both the insurer and the provider will share financial risk and engage in joint care coordination.²²¹ This deal is marketed as a competing product to the Kaiser Permanente System and has the goal of having prices at least similar to, if not lower than, Kaiser’s.²²² The partnership will arguably have control over the market and may present an issue to already struggling stand-alone hospitals or nonparticipating health systems.

2. Vertical Integration: Lacuna in the Antitrust Framework

Hospital systems recognize and respond to the fact that health insurance “does not represent the consumer [and is] not the proxy for the consumer interest.”²²³ A special loophole in vertical integration provides for vertical expansion of an existing company through offering of a new product or a service—a *de novo* entry. New health plan formation by an existing healthcare system would be an example of such transaction.²²⁴ “Organic growth” of

217. *Id.* at 91.

218. *Id.* at 93, 110.

219. MAIURO, *supra* note 107, at 9 (citing Dale Tate, *UCLA Health System, Anthem Blue Cross Join L.A. and Orange County Partners to Launch Vivity*, UCLA NEWSROOM (Sept. 17, 2014), <http://newsroom.ucla.edu/releases/ucla-health-system-anthem-blue-cross-join-l-a-and-orange-county-partners-to-launch-vivity> [<https://perma.cc/PC3P-SY6T>]); *see also* Anthem Blue Cross Partners with 7 LA/OC Health Systems to Launch Vivity, TORRANCE MEMORIAL (Sept. 18, 2014), https://www.torrancememorial.org/News_Center/2014/September/Anthem_Blue_Cross_Partners_with_7_LA_OC_Health_S.aspx [<https://perma.cc/D8J7-4H4Y>].

220. Integration between the hospitals is horizontal. Technically, it ought to be reviewed by the FTC. Integration between the insurer and the hospitals is vertical and therefore subject to the DOJ review.

221. MAIURO, *supra* note 107, at 9.

222. *See id.*

223. *Health Industry Consolidation: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means*, 112th Cong. 13 (2011) [hereinafter *Health Industry Hearing*] (prepared statement of David Balto, Senior Fellow, Center for American Progress Action Fund).

224. Vertical integration, as David Szostak notes, may be as simple as “a pharmacy opening up a line of retail clinics, employing nurse practitioners or other professionals.” Szostak,

the existing firm is not typically challenged by the federal antitrust enforcers, as it is merely a new product offering and does not involve a merger or an acquisition.²²⁵

In New York, North Shore Long Island Jewish Health System, currently Northwell Health, started CareConnect, becoming the state's first provider-owned commercial health plan.²²⁶ As the health system's first venture in the insurance business, the new plan competes with well-established and larger carriers on New York State's health insurance exchange.²²⁷ In Georgia, Piedmont Healthcare and WellStar Health System, two leaders in the metro-Atlanta healthcare market, formed Piedmont WellStar Health Plans.²²⁸ In the mid-1990s, Piedmont and WellStar participated in a joint venture, Promina Health System.²²⁹ In California, in 2013, the Sacramento-based Sutter Health network of physicians and hospitals launched its own HMO insurance coverage, Sutter Health Plus, by applying for a Knox-Keene license.²³⁰ Also in California in 2013, Memorial Care Health System started an insurance division, Seaside Health Plan.²³¹

supra note 142, at 71. Unless it is CVS deciding to acquire Aetna, there will be no challenge to such transaction.

225. SWISHER, *supra* note 212, at 1.

226. Terry Lynam, *While Preserving Its Population Health Commitment, Northwell to Withdraw CareConnect from NYS Insurance Market*, NORTHWELL HEALTH (Aug. 24, 2017), <https://www.northwell.edu/about/news/press-releases/while-preserving-its-population-health-commitment-northwell-withdraw-careconnect-nys-insurance-market> [https://perma.cc/2297-PCFJ].

227. Most recent news broke out in August 2017, when Northwell announced they were closing CareConnect and exiting insurance market gradually—at that point around 120,000 were enrolled in the plans. Claude Solnik, *Northwell to Close CareConnect*, LIBN.COM (Aug. 24, 2017), <http://libn.com/2017/08/24/northwell-to-close-careconnect> [https://perma.cc/25QX-DCVF].

228. Andy Miller, *Piedmont, WellStar Cutting Back on Health Plan*, GA. HEALTH NEWS (Sept. 25, 2015), <http://www.georgiahealthnews.com/2015/09/piedmont-wellstar-cutting-health-plan> [https://perma.cc/N573-GEL2] (noting the plan was launched in 2013 and scaled back after two years of operations).

229. *Id.*

230. See *Sutter Health Unveils Name of New Health Plan*, SUTTER HEALTH (June 6, 2013), <https://news.sutterhealth.org/2013/06/06/sutter-health-unveils-name-of-new-health-plan/> [https://perma.cc/2T3S-9SLZ]. A Knox-Keene license is required to operate a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975. *Knox-Keene Overview*, GARNER HEALTH L. CORP., <http://garnerhealth.com/knox/> [https://perma.cc/LSG2-RKMC]; see CAL. HEALTH & SAFETY CODE § 1349 (West 2017).

231. *Seaside Health Plan*, MEMORIALCARE, <https://www.memorialcare.org/guides-tools/seaside-health-plan> [https://perma.cc/4XCE-LKJY].

The aftermath of the new entries proves it may be easier to enter insurance markets with a regulated insurance product, such as Medicare Advantage.²³² Larger systems do have an advantage: the insurance products are utilizing their existing systems in a *complex deal*.²³³ Examples of health systems going this route are Geisinger Health System with its Geisinger Health Plans,²³⁴ or John Hopkins Medicine with the John Hopkins HealthCare.²³⁵

Launching their own insurance product can allow hospitals to follow the Kaiser path—consolidate care, reduce their own insurance costs, improve margins, and accordingly put their competitors, both *pure* insurers and *pure* healthcare providers, in a competitive disadvantage.²³⁶ Although not engaging in price-fixing practices, potential elimination of competitors, who simply are not able to survive in the world of declining margins, can allow dual providers to increase prices in the long run.

Vertical arrangements are overall “less likely to raise antitrust concerns.”²³⁷ Only fifty-eight vertical mergers were challenged between 1994 and 2018, and only four of them were related to the healthcare or pharmaceutical field.²³⁸

Ultimately, a provider–payer duality enables a hospital, or health system for that purpose, to form a narrow network²³⁹ and tier away competitors without direct one-on-one negotiations with a third party.²⁴⁰ Competitors

232. See MILLER & WOLFE, *supra* note 145, at 7.

233. *Id.*

234. See *Health Insurance Plans that Meet Your Needs*, GEISINGER CARING HEALTH PLAN, <https://www.geisinger.org/health-plan> [<https://perma.cc/5C67-5LWC>].

235. See *Johns Hopkins HealthCare LLC*, JOHNS HOPKINS MED., https://www.hopkinsmedicine.org/johns_hopkins_healthcare/index.html [<https://perma.cc/5A2Q-SYFQ>].

236. See MAIURO, *supra* note 107, at 17–18.

237. MILLER & WOLFE, *supra* note 145, at 3.

238. See generally STEVEN C. SALOP & DANIEL P. GULLEY, VERTICAL MERGER ENFORCEMENT ACTIONS: 1994–JULY 2018 (2018), <http://scholarship.law.georgetown.edu/facpub/1529/>.

239. A narrow network is the insurance product that limits the patients’ choice of providers within the health plan’s network. *Methodist Health Servs. Corp. v. OSF Healthcare Sys.*, No. 1:13-cv-01054-SLD-JEH, 2016 WL 5817176, at *2 (C.D. Ill. Sept. 30, 2016) (describing narrow network as incentivizing insurers to send the beneficiaries to in-network providers and as desirable to providers due to the increased patient volume). It is an important negotiating point between an insurer and a healthcare provider and significantly impacts prices the consumer pays for healthcare services. *Dicesare v. Charlotte-Mecklenburg Hosp. Auth.*, No. 16 CVS 16404, 2017 WL 1359599, at *4 (Sup. Ct. N.C. Apr. 11, 2017) (referring to narrow networks as “popular steering tools”). A narrow network significantly limits the patient’s access to out-of-network providers and is analyzed in antitrust law from the exclusivity perspective. *Id.*; *Methodist Health*, 2016 WL 5817176, at *2.

240. Mark Botti, Partner, Squire Paton Boggs LLP, Roundtable: Antitrust Perspectives on Evolving Provider and Payment Models (Feb. 25, 2015), in WORKSHOP TRANSCRIPT: EXAMINING HEALTHCARE COMPETITION 132 (2015), https://www.ftc.gov/system/files/documents/public_events/618591/transcript-day2.pdf [<https://perma.cc/SUN6-JZVD>].

do not have the power to negotiate—they will be by default in a tier subordinate to the provider–payer system. Kaiser does not compete with others for providing healthcare services. Instead, others compete with Kaiser for member lives, for customers who choose Kaiser to be their insurance provider and, correspondingly, the care provider. The “attribution of population”²⁴¹ impact to the market is hardly explored.

Meanwhile, the ability to form its own health plan allows a health system to “level the playing field against dominant insurers.”²⁴² Certainly, there are concerns of potential negative reaction from the major insurance companies if a health system opens up its own insurance arm,²⁴³ but the recent wave of vertical integration hints that this concern is without merit. Longevity of the enterprise is another issue, but this Comment treats it as secondary to the possibility of a relatively easy market entry that is not subject to the traditional antitrust scrutiny of vertical mergers. Moreover, based on the discussed examples, such market entry is possible primarily, if not exclusively, for larger, integrated health systems.

3. ACO: Ambiguity Around the “Vertical Integration” Revisited

ACOs present an interesting phenomenon of three-fold integration: physicians, hospitals, and insurers.²⁴⁴ Although hospital participation is not a required element of an ACO, it certainly enhances the organization’s efficiency in providing a care continuum and engaging in population health management. The insurer also participates indirectly through risk sharing with the healthcare provider—stopping just “short of [a] merger”²⁴⁵ if it is at all possible to be in such a close relationship with Medicare, a governmental payer, that is central to the ACO development.

241. *Id.* at 133.

242. CANTOR & KOURY, *supra* note 83, at 2.

243. A possible fear is that the existing contracts will be endangered. However, when the health system is well established in the region that concern is probably less.

244. ACOs are designed to strengthen vertical integration between the healthcare players. See MILLER & WOLFE, *supra* note 145, at 6. Run by CMMI, they are to bring together efforts of the insurer and the provider. *Id.*

245. Martinez et al., *supra* note 117.

a. *Formation of the ACO: Review and Lack Thereof*

ACO formation is not subject to a regulatory challenge as long as the ACO meets the CMS eligibility criteria.²⁴⁶ At this point, ACO formation is solely federally regulated. Although a few states have passed ACO certification programs,²⁴⁷ the majority of states do not have any guidelines. Medicare's general eligibility requirements for MSSP ACO participation are relatively easy to meet for established—and especially integrated—systems.²⁴⁸

Antitrust review pre-formation is not efficient, as it only applies to independent entities that are entering into an ACO as a form of collaboration—independent physicians, for example. Integrated delivery systems are exempt from antitrust scrutiny as a part of the approval process.²⁴⁹ This relaxed approach may serve as a tempting incentive to form an ACO to coordinate care, share information, and control spending while increasing the market power and strengthening the competitive position.

246. The FTC and DOJ have provided guidance on ACO formation and as long as it is followed, the ACO can expect “rule of reason” be applied to its operations. *Antitrust Laws Exist to Protect Consumers, Not Providers*, MOD. HEALTHCARE (Apr. 19, 2014) [hereinafter *Antitrust Laws Protect Consumers*], <http://www.modernhealthcare.com/article/20140419/MAGAZINE/304199951> [<https://perma.cc/65VS-TG6H>] (citing Markus Meier, Assistant Director for Healthcare Enforcement, Bureau of Competition, Federal Trade Commission). Therefore, formal procedures are primary in decisions on whether federal regulators will examine an ACO for anti-competitive methods of operations. *See id.*

247. These states are Texas, Massachusetts, and New York. Matt Goodman, *Dallas-Based ACO is First in North Texas to Earn Rare Certification*, DCEO HEALTHCARE (Mar. 12, 2015), <http://healthcare.dmagazine.com/2015/03/12/dallas-based-aco-is-first-in-north-texas-to-earn-rare-certification> [<https://perma.cc/A2X2-TL3E>]; Rajiv Leventhal, *Massachusetts ACO Certification Program Now Includes 17 Members*, HEALTHCARE INFORMATICS (Jan. 5, 2018), <https://www.healthcare-informatics.com/news-item/value-based-care/massachusetts-aco-certification-program-now-includes-17-members> [<https://perma.cc/XE22-LB74>]; Neal N. Peterson, *Proposed Regulations in New York for ACO Certification Reflect Medicare Shared Savings Program Influence*, DORSEY (Nov. 25, 2014), https://www.dorsey.com/newsresources/publications/2014/11/proposed-regulations-in-new-york-for-aco-certifi__.

248. An ACO must be a legal entity formed under the applicable state law and authorized to conduct business in the respective state, which would allow the ACO to receive shared savings payments. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE SHARED SAVINGS PROGRAM, MEDICARE ACO TRACK 1 + MODEL, AND SNF 3-DAY RULE WAIVER: 2018 APPLICATION REFERENCE MANUAL 41 (2017). In addition, an ACO must have a governing body, at least 75% of which is held by the ACO participants—physicians or hospitals. *Id.* at 45. Finally, an ACO must have a minimum of 5,000 of aligned beneficiaries—this number is determined by services previously provided to the beneficiaries by the participating providers. DEP'T OF HEALTH & HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., SUMMARY OF THE JUNE 2015 FINA RULE PROVISIONS FOR ACCOUNTABLE CARE ORGANIZATIONS (ACOs) UNDER THE MEDICARE SHARED SAVINGS PROGRAM 4 (2016).

249. *ACO Statement*, *supra* note 108, at 67027.

The FTC and DOJ provided in the *ACO Statement* that mere participation in one of the Medicare programs avoids integration questions.²⁵⁰ The FTC stated that if an ACO participates in the Shared Savings Program and follows identical processes in the Medicare and commercial markets, it is safe to operate with commercial payers as well.²⁵¹ Consequently, for an ACO participating in CMS programs, expansion to the commercial market is basically guaranteed.²⁵²

Moreover, exclusively private ACOs are not regulated on the same level as Medicare ACOs.²⁵³ The guidance by the FTC and DOJ is primarily directed at Medicare ACOs although there is express language including commercial ACOs' in the pool: "The Policy Statement is intended to ensure that health care providers have the antitrust clarity and guidance needed to form procompetitive ACOs that participate in both the Medicare and commercial markets. . . ."²⁵⁴ and "[t]he analytical principles underlying the Policy Statement also would apply to various ACO initiatives undertaken by the Innovation Center within CMS *as long as those ACOs are substantially clinically or financially integrated.*"²⁵⁵

However, the *ACO Statement* was issued in 2011, at the relatively early stages of commercial ACO development and is not reflective of the character of the ACO establishment today. There is no distinctive standard for a commercial ACO structure or a specific guidance on how to form a procompetitive commercial ACO. Therefore, in addition to the *ACO Statement*, traditional joint venture analysis should be applicable to commercial ACOs.²⁵⁶ The safety zone exception would be granted if the financial integration is

250. *Id.* at 67026–29. Participation in the MSSP is the "proxy for integration." David W. Simon & H. Holden Brooks, *Federal Antitrust Enforcement in Healthcare*, ACC (Jan. 3, 2012) <http://www.acc.com/legalresources/quickcounsel/faeihc.cfm> [https://perma.cc/KSQ5-KSM7].

251. *Antitrust Laws Protect Consumers*, *supra* note 246.

252. Contracts with private payers are subject to rule of reason analysis as opposed to being treated as per se violation. Simon & Brooks, *supra* note 250.

253. Jaime King & Erin Fuse Brown, *New Health Care Symposium: States' Critical Role Overseeing Vertical Health Care Integration*, HEALTH AFF. (Mar. 3, 2016), <http://healthaffairs.org/blog/2016/03/03/new-health-care-symposium-states-critical-role-overseeing-vertical-health-care-integration> ("[T]here is no regime of oversight for commercial ACOs.").

254. *ACO Statement*, *supra* note 108.

255. *Id.* at 27026 n.7 (emphasis added).

256. Traditional joint venture analysis evaluates the market and the competition and not necessarily the ACO structure and affiliations.

sufficient to justify joint sales—if the market share is no more than 20%²⁵⁷ and if no multi-provider network is involved.²⁵⁸ The *ACO Statement*, unlike the 1996 *Statements*,²⁵⁹ defines “market” and “service,” but the definitions are loose and concentrated strictly on the geographical location of business.²⁶⁰

Commercial ACOs’ operations and practices are allegedly significantly different from those of Medicare ACOs. They are subject to fewer federal regulations and requirements, and they have the negotiable terms with the ultimate payer.²⁶¹ Commercial ACOs may also have different payment mechanisms, such as capitation or FFS with only one feature in common with the Medicare *sibling*—generating savings while preserving quality of care.²⁶² One reason to create Medicare ACOs is to *share* savings or losses with Medicare, or the government, based on the population that is assigned to the payer by the existing policy.²⁶³ In the commercial ACO world, where managed beneficiaries join supposedly willfully, the savings are coming, not from and for the government payer—and ultimately taxpayers—but for *pure* business organizations bearing the risk, be it healthcare providers or insurers.

Another antitrust aspect arises when an ACO—most often commercial, but sometimes Medicare as well—is a fully-owned subsidiary of a larger health system.²⁶⁴ There is no standard set by the FTC and DOJ on how that

257. Twenty percent is for exclusive networks; for non-exclusive networks, it is 30%. ROBERT BELFORT & MARTIN THOMPSON, AVOIDING REGULATORY LAND MINES IN COMMERCIAL ACOS 5 (2014). However, the main focus is clinically integrated networks—in highly fragmented market, 20% market share is extremely high. As an example, the San Diego market is divided in the following manner: Sharp HealthCare has market share of 27%, Scripps Health has 25%, everyone else is well below 20%. Ha Tu, Joy Grossman & Peter Cunningham, *San Diego: Health Care Providers Expand Capacity as Competition Increases for Well-Insured Patients*, CAL. HEALTH CARE ALMANAC, Jan. 2013, at 1, 3–4.

258. THE STATEMENTS, *supra* note 86, at 114–15.

259. Compare *ACO Statement*, *supra* note 108, with THE STATEMENTS, *supra* note 86, at 114–15.

260. The “safety zone” exception for Medicare ACOs is available if each of the participant’s market share in the primary service area does not exceed 30%—or 20% for exclusive networks. *ACO Statement*, *supra* note 108, at 67028.

261. “An ACO is in the eye of the beholder and the federal version is much different from the commercial.” Larkin, *supra* note 195 (quoting Robert Cimasi). Robert Cimasi, a healthcare consultant, believes diversity of ACOs in the current market reflects the flexibility of regulations, especially in the private market. *Id.*

262. *Id.*

263. Medicare is “government insurance” available to a certain segment of the population. Daniel Marans, *Insurance Companies Just Accidentally Made the Case for Medicare for All*, HUFFPOST (Mar. 9, 2017, 3:51 PM), https://www.huffingtonpost.com/entry/insurance-companies-medicare-for-all_us_58c1b1fae4b054a0ea690dc8 [<https://perma.cc/43Z7-GTA7>].

264. A list of notable ACOs is published annually, and the following stand out due to the coverage and well-established organization behind them, such as the following: Advocate Healthcare—Illinois, over 1,800 participating providers, agreements with Blue Cross Blue Shield and UnitedHealthcare, participation in MSSP program; Allina Health—

should impact the initial antitrust analysis *clearing up* the new ACO to proceed. It matters because in the case of a large organization being a sole owner, it would all but ensure the absence of antitrust concerns.²⁶⁵

b. ACO Market Share Analysis

A grey area is whether a commercial ACO's market share affects the prices paid by private insurers and therefore constitutes illegal price fixing.²⁶⁶ However, antitrust concerns are "subject to [the] 'rule of reason' test," which is passed if the ACO is financially and clinically integrated, with the integration benefits outweighing anticompetitive impacts.²⁶⁷ Given the high costs of becoming an ACO and functioning as one, a great share of ACO providers are an already established system, especially when a hospital is involved.²⁶⁸ What are the chances the FTC or DOJ would challenge the ACO formation in this case? Private antitrust lawsuits are also unlikely due to costs and burden to the plaintiff.²⁶⁹

The FTC and DOJ *ACO Statement* establishes an antitrust safety zone for ACOs that satisfy CMS' final rule and meet market share and exclusivity requirements.²⁷⁰ Interestingly enough, all ACOs, regardless of composition—physicians exclusively or physicians and hospitals—are treated the same by the *ACO Statement*, whereas the FTC and DOJ *Statements* clearly state

Minnesota, "one of the . . . original Pioneer ACOs," covers over 300,000 beneficiaries; Banner Health Network—Arizona, Pioneer ACO, agreements with Aetna, Cigna, and UnitedHealthcare; Cleveland Clinic—Ohio, MSSP, over 2,800 participating providers, agreement with Cigna; and Fairview Health System—Minnesota, Pioneer ACO, Fairview and North Memorial Vantage with Medica. *100 Accountable Care Organizations to Know 2015*, BECKER'S HOSP. R. (Sept. 23, 2015), <https://www.beckershospitalreview.com/lists/100-accountable-care-organizations-to-know-2015.html> [<https://perma.cc/WL5B-HAXR>].

265. A single entity legally cannot enter into an agreement with itself and restrain competition. *See* *Am. Needle, Inc. v. NFL*, 560 U.S. 183, 194 (2010) ("[A] parent corporation and its wholly owned subsidiary 'are incapable of conspiring with each other for the purposes of § 1 of the Sherman Act' . . ." (quoting *Copperweld Corp. v. Indep. Tube Corp.*, 467 U.S. 752, 777 (1984))).

266. *See* Belfort, *supra* note 176.

267. *Id.* A bigger health system, such as Geisinger and Sharp, typically would not have an issue to demonstrate clinical and financial integration.

268. "According to the 2013 AHA survey, ACO hospitals are three times more likely to be urban and more than twice as likely to be teaching institutions and system-affiliated than non-ACO hospitals." Larkin, *supra* note 195.

269. The "plaintiff must show the loss of . . . business will have an impact on competition and consumers." Greaney & Ross, *supra* note 99, at 223. This is a fact-intensive inquiry; establishing competitive harm is difficult. *See id.* at 224.

270. *See ACO Statement*, *supra* note 108, at 67028.

that organized provider networks are subject to a greater antitrust scrutiny.²⁷¹ This presents a discrepancy between the two guidelines and suggests a possibility that already integrated providers may want to utilize ACO as a shelter to avoid additional scrutiny by the antitrust watchdogs. In the discussions of the ACO formation, there was a significant push to provide for relaxed antitrust standards for physician-owned ACOs as a means to establish adequate competition for hospital-dominated markets and therefore for the federal agencies to “broaden the standards for integration . . . in evaluating proposed ACOs.”²⁷² Apparently, this goal has been achieved, but the relatively relaxed standards were established for *all* ACOs as the result.

CMS indicates that ACOs shall exercise rule of reason and voluntarily request antitrust clearance from the FTC or DOJ.²⁷³ However, this clearance is not a requirement.²⁷⁴ Besides, the process of obtaining an advisory opinion from the federal agency is “lengthy and costly.”²⁷⁵ Although the FTC and DOJ state that they either have examined or will examine any ACO with physician members representing more than 30% of the market share in a specialty, it is unlikely to occur in the fragmented healthcare market.²⁷⁶

There is a correlation between the HMO market share and the ACO enrollment, indirectly suggesting that ACOs and HMOs are competitors, and the ACO model may be an alternative product to a traditional HMO system.²⁷⁷ Health plans, especially employer-owned ones, may be recognizing the negative reputation of HMO insurance products and are attempting to offer an alternative, especially considering the frustrations in the HMO system over referrals and cost-saving techniques.²⁷⁸ For hospital systems, ACOs may become one of the ways to rebrand and become “a convener of health resources” as opposed to being a mere “provider of hospital beds.”²⁷⁹

271. THE STATEMENTS, *supra* note 86, at 3–4.

272. BALTO, *supra* note 185, at 17.

273. ACO Statement, *supra* note 108, 67842.

274. In her speech from 2014, Deborah Feinstein, FTC commissioner, stated that “[o]nly two ACOs . . . requested antitrust review” by the FTC. FEINSTEIN, *supra* note 96, at 6.

275. Belfort, *supra* note 177; *see also* BALTO, *supra* note 185, at 9 (“The cost of securing a business review letter from the FTC . . . is now well more than \$100,000 . . .”).

276. David Dranove, *ACOs and Antitrust: A Few Words of Caution*, HEALTH CARE BLOG (June 26, 2012), <http://thehealthcareblog.com/blog/2012/06/26/acos-and-antitrust-a-few-words-of-C2%A0cautio/> [<https://perma.cc/JSS3-2XSS>].

277. *See* STEPHEN M. SHORTELL ET AL., ACCOUNTABLE CARE ORGANIZATIONS IN CALIFORNIA: PROMISE & PERFORMANCE 15 (2015), http://berkeleyhealthcareforum.berkeley.edu/wp-content/uploads/BerkeleyForumACOExpBrief3_feb16.pdf [<https://perma.cc/8UU6-FB2A>].

278. *See* LANDERS-NELSON ET AL, *supra* note 166, at 4 (“Health plans and employers received a great deal of blowback in the 1990s from employees over frustrations with health maintenance organizations (HMOs), especially about referral procedures and the perception that plans and providers were denying necessary care to save money.”).

279. Larkin, *supra* note 195.

Specifically, in an employer ACO, employers have multiple means of financially incentivizing employees to participate in an employer-sponsored ACO and therefore increase cost controls over the continuum of care.²⁸⁰ The size of the employer may significantly impact the market power of the ACO that contracted with such an employer. The financial incentives from employers are unquestionably legal, but they raise antitrust concerns; for example, a conduct for ACOs to avoid is “[p]reventing or discouraging private payers from incentivizing patients to choose certain providers,” whether inside or outside the ACO.²⁸¹ If the employer serves as an ACO or directly contracts with an ACO and administered the health plan for the employees, this conduct should at least seem questionable. The similarity to the HMO plan is obvious in this case: the healthcare provider, the ACO, is accountable for elimination of unnecessary cost and bears the financial risk. The attribution of a patient to the ACO provider in a commercial—and especially employer—environment seems to be less intuitive and willful than in a Medicare environment.²⁸²

An ACO achieves efficiency when it reaches the right size to be able to effectively control the aligned population and reduce costs, but this efficiency is only up to the point when it starts “stifling competition.”²⁸³

4. Traditional Vertical Merger Analysis Does Not Capture New Trends

Vertical transactions in healthcare have become more complex in the past decade due to three main trends: (1) increase in traditional vertical mergers, (2) vertical consolidations and *de novo* entries to market segments that previously were traditionally separate, and (3) emerging concept of population health and risk sharing represented by ACOs. The *Vertical*

280. Some financial incentives include: Health Reimbursement Account (HRA) or Health Saving Account (HAS) deposits for choosing to participate in an ACO; smaller deductibles for seeking services within the ACO network; and reduced co-pays or deductibles for services received from the ACO providers. LANDERS-NELSON ET AL., *supra* note 166, at 6.

281. *ACO Statement*, *supra* note 108, at 67030.

282. Voluntary selection of care provider at all times and no need in referrals are the key features that are supposed to distinguish an ACO from an HMO. See Blackstone & Fuhr, *supra* note 156, at 13; see also *supra* text accompanying note 200.

283. Morton, *supra* note 5.

Merger Guidelines, last revised in 1984, cannot possibly reflect these trends.²⁸⁴

The FTC and DOJ warn that each set of guidelines cannot possibly embrace all merger scenarios.²⁸⁵ Still, tools or methodologies used by the regulators, should be comprehensive and contemplative of the current trends. Evidently, the integration level comes to light when assessing potential antitrust violations in addition to analyzing the impact on the competitors.²⁸⁶ The level of vertical integration, specifically, is hard to assess. Given the historical trend of viewing vertical structures as “procompetitive,”²⁸⁷ existing antitrust regulations fail to address their impacts on the healthcare landscape and the opportunities resulting from the lack of regulations.

IV. PROPOSED UPDATE TO FEDERAL REGULATION OF PROVIDER-OWNED PLANS AND ORGANIZATIONS FUNCTIONING AS PROVIDERS AND PAYERS

In one of the recent Next Generation ACO webinars, CMMI personnel referred to ACO as a “virtual health plan.”²⁸⁸ This approach perfectly reflects the view authorities have over the phenomenon that is rapidly growing and expanding into spheres other than Medicare.²⁸⁹ Simultaneously, this approach outlines the problem in regulating it: the current regulatory framework is simply not prepared for the consolidated treatment of insurer and payer, which exists not only in the ACO model, but also in the provider-owned health plans.²⁹⁰ This Comment will not provide a comprehensive solution to all regulation issues arising out of the dual provider–payer structure. However, it proposes the solution to the antitrust challenges that arise out of the loopholes created by the structural changes in healthcare over the last decade. This proposed solution includes updates to the regulations

284. Nowhere in the *Vertical Merger Guidelines* there is a reference to the phenomena specific to post-ACA enactment healthcare. *See generally* NON-HORIZONTAL MERGER GUIDELINES, *supra* note 90.

285. “[M]erger analysis does not consist of uniform application of a single methodology. . . . [T]hese Guidelines . . . are illustrative and do not exhaust the applications of the relevant principle.” HORIZONTAL MERGER GUIDELINES, *supra* note 89, at 1.

286. Assessing the level of integration is not an easy task as it is fact specific and may incorporate such factors as capitation arrangements, centralization of services, and central monitoring and review functions implemented in the healthcare organization. *See* Cohen, *supra* note 186.

287. MILLER & WOLFE, *supra* note 145, at 4.

288. Webinar: Next Generation ACO Model: Lesson Learned and Planning for Participation (CMMI 2017).

289. *See supra* text accompanying note 177.

290. *See supra* text accompanying note 135.

over vertical integration that will specifically address the provider–payer collaboration through the methods described in the following section.

A. Update to Vertical Integration Guidelines

Providers may undertake payer roles for different reasons: they may genuinely believe that such models will become mandatory at a point, they may want to gain exposure to the risk sharing environment, or they have a greater interest in care coordination and better alignment.²⁹¹ Regardless of what those reasons are, the underlying goal is vertical integration.

Vertical integration and the unique provider–payer nature of healthcare organizations in the recent trend raise antitrust issues that have not been previously brought up. There is no per se violation of the current law. Meanwhile, the guidelines to healthcare mergers, which are a joint effort by the FTC and DOJ, have remained unchanged since 1996.²⁹² Overall, the application of antitrust principles in healthcare is a complex endeavor due to the rule of reason balancing test, but the “market imperfections and the rapid pace of change” complicate it even more because relying on the case law and prior advisory opinions issued by the agencies is problematic in the wave of change.²⁹³ Formal regulations need to be introduced specifically for the healthcare field²⁹⁴ and independent from potential changes to the ACA.

291. See Alison Fleury, Senior Vice President, Sharp HealthCare, Early Observations Regarding Accountable Care Organizations, in WORKSHOP TRANSCRIPT: EXAMINING HEALTHCARE COMPETITION, *supra* note 240, at 22.

292. The *Vertical Merger Guidelines* have not been revised since 1984. See *supra* text accompanying note 284. The *Horizontal Merger Guidelines* have not been revised since 2010. See *supra* note 92.

293. Greaney & Ross, *supra* note 99, at 202 (“[A]pplying antitrust principles in healthcare is always a tricky undertaking, as market imperfections and the rapid pace of change make predictions predicated on the past unreliable.” (citing Thomas L. Greaney, *Chicago’s Procrustean Bed: Applying Antitrust in Health Care*, 71 ANTITRUST L.J. 857 (2004))). The changes following the ACA enactment have been even more rapid than anything prior and there is virtually no precedent to base a decision on. The potential repeal of the ACA does not impact the difficulty of the decision. If the repeal takes place it will not revert the healthcare to the pre-ACA era.

294. Again, currently healthcare does not enjoy a separate treatment; it qualifies as one of the “learned professions” under *Goldfarb* and falls under standard antitrust analysis. *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975). However, the existence of healthcare-specific Guidelines indicates that at least partial separation and unique antitrust nature of healthcare is admitted by the Agencies. See generally THE STATEMENTS, *supra*

Referring to healthcare regulations, today mostly everyone expresses concern regarding the ACA repeal by the current Administration. This Comment asserts that the potential impacts of the repeal cannot stop the market developments. Once consolidation has started, it is extremely hard to stop. The ten years under the ACA have changed the way health systems operate. Therefore, no matter what the fate of the ACA is, updated antitrust regulations should be adopted or current antitrust guidelines should be adjusted to allow the government to properly analyze the new structures.

B. Areas for Regulatory Revision

The updated regulations should reflect a few important areas that are discussed below. In healthcare, the whole purpose of antitrust laws is to ensure a competitive marketplace and quality of care; reduction in competition is not permitted “simply because it may appear to lead to lower prices.”²⁹⁵ The dual nature of provider-insurer needs to be recognized along with the issues that arise out of it. If new regulations are not introduced, there is a risk of repeating the managed care scenario from twenty years ago—from its appearance and the original enthusiasm of the market, to the high expectations surrounding it, up to its dawn in many parts of the country.²⁹⁶ This Comment analyzes the traditional loopholes; eliminating them will significantly improve efficiency of antitrust regulations in the current environment. Particularly, the following require an update in the regulations:²⁹⁷ case-by case transactions; the definition of *product* as applied to healthcare; the definition of *healthcare market*; approaches to data sharing; control over narrow networks, reporting requirements; and, last but not least, authority over enforcement.

Case-by-Case Transactions. Federal regulators are currently examining transactions on case-by-case basis. As stated in the *Horizontal Merger Guidelines*, “merger analysis . . . is a fact-specific process through which the Agencies, guided by their extensive experience, apply a range of analytical tools to the reasonably available and reliable evidence.”²⁹⁸ However, with the influx in volume of vertical integrations, it is unrealistic to expect that the agencies would have “the resources or the capacity”²⁹⁹ to review

note 86. Regulators do realize that the challenges here are quite different from other sectors; however, further development is needed.

295. *Health Industry Hearing*, *supra* note 223.

296. Managed care concept is still utilized—for example, HMO products—but not all organizations are willing to engage in it; those who do, however, are much better situated to the continuum of care framework.

297. Proposed mechanisms are discussed in the corresponding sub-sections.

298. HORIZONTAL MERGER GUIDELINES, *supra* note 89, at 1.

299. King & Brown, *supra* note 253.

all transactions taking place in the United States.³⁰⁰ Antitrust analysis in each rule of reason case starts with definition of the product market. In the provider-payer organization case, this presents two issues: (1) what is the product, and (2) what is the market.

Product Definition. Regulators are used to treating *products* as divided by services provided.³⁰¹ This approach requires a revision. *Product* in integrated organizations is essentially the continuum of care, from providing health insurance coverage to providing treatment services. The main competitors would be *pure* insurers, *pure* healthcare providers, and all existing dual provider-payer organizations.

Market Definition. Both ACO and provider-owned plan arrangements trigger market power concerns, which is overall one of the key antitrust issues.³⁰² However, the definition of market utilized by the antitrust enforcers and based mostly on the geographic location is outdated,³⁰³ and revisions to the concept of *market* are crucial to appropriately apply antitrust regulations. Back in 1990, Judge Posner said, “People want to be hospitalized near their families and homes, in hospitals in which their own—local—doctors have hospital privileges.”³⁰⁴ However, healthcare has changed since the 1990s, and geographical market share is no longer expressed through zip codes.³⁰⁵

300. As Feinstein puts it, “[f]or every transaction that [the FTC] challenge[s], there are many more that [the FTC] determine[s] do not warrant a challenge. In most cases, [the FTC] do[es] not make public [their] decisions not to take action against a particular arrangement because of confidentiality concerns.” FEINSTEIN, *supra* note 96, at 9. This assertion is vague, not unlike antitrust laws, and does not provide reassurance that all—or at least most—transactions that are potentially violating antitrust principles receive necessary review.

301. See *Cascade Health Sols. v. PeaceHealth*, 515 F.3d 883, 891 (9th Cir. 2008) (“Primary and secondary . . . hospital services are common medical services like setting a broken bone and performing a tonsillectomy [whereas] ‘tertiary care’ . . . includes more complex services like invasive cardiovascular surgery and intensive neonatal care.”).

302. “Antitrust enforcement helps ensure potentially more efficient ways of delivering and financing health care can develop and compete, while preventing accumulations of market power that harm competition.” ROBERT S. CANTERMAN, ANTITRUST AND COLLABORATION IN HEALTH CARE 10 (2016), https://www.americanbar.org/content/dam/aba/administrative/healthlaw/15_canterman.authcheckdam.pdf [<https://perma.cc/5A74-YVB4>].

303. Court decisions “stretch[] the geographical boundaries”—although there is a view this is done to prevent antitrust litigation. *Hammer & Sage*, *supra* note 17, at 90 (citing *United States v. Mercy Health Servs.*, 902 F. Supp. 968, 972 (N.D. Iowa 1995), *vacated*, 107 F.2d 632 (8th Cir. 1997)) (defining a geographic market around Poplar Bluff, Missouri to “include[] hospitals 70–100 miles away”).

304. *United States v. Rockford Mem’l Corp.*, 898 F.2d 1278, 1285 (7th Cir. 1990).

305. There has not been major litigation to apply revised approaches to market that would reflect the new products and boundaries these products are functioning in. See *Hammer & Sage*, *supra* note 17, at 90.

Accordingly, the character of the merger is no longer merely geographical as the service lines are blending. Therefore, the key metrics of assessing merger anticompetitive effects—Herfindahl-Hirschman Index³⁰⁶—needs an equivalent *native* to healthcare.³⁰⁷ The focus on care continuum begs the question, what could be a better basis for market share calculation? Is it geographic market, or covered beneficiaries, or provided services, or maybe even realized benefit? There is a blend between insurer and healthcare provider, and this new blended category should be recognized and receive its own appropriate treatment and measurement as antitrust assessment of market power is concerned.

Data Sharing and Unfair Competitive Advantage. Sharing insurer and care provider information leads to more efficient care and cost reductions.³⁰⁸ Data exclusivity in the modern age may have anticompetitive impacts, especially healthcare charges and competitor cost data. Some states have started to address data sharing controversy by creating a centralized all-payer claims database (APCD).³⁰⁹ APCD “is an electronic system that aggregates claims and [corresponding] administrative data from [government] and private payers.”³¹⁰ It is a state-driven effort, and the rules for what information may be collected and how it shall be collected vary based on the state.³¹¹ Standardization is necessary. Availability of and access to a federal claims database would decrease the incentive for vertical integration for the sole purpose of gaining access to data. It would also provide for equal access to data for all players in the market, regardless of their size. Therefore, participation in such database should be mandated for organizations wishing to participate in a provider–payer relationship.

306. The Herfindahl-Hirschman Index (HHI) is a standard market concentration measure that is determined by (1) calculating every relevant firm’s market share, (2) squaring each market share, and (3) calculating the sum of the squares. MILES, *supra* note 70, at 22. The higher the value, the higher the market concentration and, correspondingly, the closer the firm is to a monopoly. *See id.*

307. The FTC weighs the HHI—specifically changes in the HHI as it relates to a merger—heavily in antitrust analysis. *See* HORIZONTAL MERGER GUIDELINES, *supra* note 89, at 18–19.

308. Data availability provides healthcare providers opportunities for improvement. *See* Botti, *supra* note 240. Research also shows merged firms lower their costs by 5–14% on average. *See* Teresa D. Harrison, *Do Mergers Really Reduce Costs? Evidence from Hospitals*, 49 ECON. INQUIRY 1054, 1055 (2011).

309. Currently, nineteen states have passed legislation that enables the collection of healthcare claims data. *APCD Legislation by State*, APCD COUNCIL, <https://www.apcdouncil.org/apcd-legislation-state> [<https://perma.cc/SV9U-RKNK>].

310. Evan Sznol, *Issue Brief: All Payers Claims Databases*, SOURCE BLOG (June 19, 2015), <http://sourceonhealthcare.org/issue-brief-all-payer-claims-databases/> [<https://perma.cc/6J77-JK2Z>].

311. *Id.*

Narrow Networks and Increased Negotiating Power. By nature, the provider–payer organization structure represents a narrow network that is artificially limited.³¹² As long as it does not harm the consumer, the agencies usually do not have antitrust concerns that arise out of mere narrow network formation. However, some believe “narrow networks can be a tool for payers to cause competition”,³¹³ correspondingly, provider-payers can use narrow networks to reduce competition both from other payers and from other providers, thus impacting two traditional markets at the same time. In a provider–payer arrangement, insurance companies are no longer the main *customer* responsible for payment and negotiating rates. Instead, the patient is the customer choosing the insurance service. There needs to be an adjustment of narrow network definition specifically acknowledging a provider–payer structure and a stricter examination of such. Negotiating power is important; however, the basis of the negotiating power becomes unclear in the absence of the insurance as a third party, a middleman, and the risk-bearer. Price to the consumer exclusively may be a plausible option, but price in the healthcare market is not always an adequate measure for antitrust analysis nor is it the primary factor patients base their provider choice on.³¹⁴ Increased bargaining power of the payer-provider in the absence of a middleman, or a traditional health insurance plan, provides a competitive advantage.

Pre-Formation Reportability. Pre-formation reportability should become a requirement regardless of the estimated value of transaction. Safety zones are an easy way to avoid scrutiny.³¹⁵ Obviously, reviewing each and every transaction is not feasible; however, reportability is better based exclusively on the size of the competitors and, possibly, on the market share transaction participants hold as opposed to the mere size of the transaction. Factoring in HHI will also provide for more consistent review. Alternatively, reportability requirements must embrace a greater variety of collaborations, as opposed to including only traditional mergers, and must also extend to *de novo* transactions³¹⁶ for established market participants over a certain size.

312. See *supra* note 239.

313. Tara Koslov, Deputy Director, FTC, Office of Policy Planning, Roundtable: Antitrust Perspectives on Evolving Provider and Payment Models, in WORKSHOP TRANSCRIPT: EXAMINING HEALTHCARE COMPETITION, *supra* note 240, at 129–30.

314. *Health Industry Hearing*, *supra* note 223.

315. See *supra* text accompanying note 87.

316. For discussion of qualifying *de novo* transactions see *supra* text accompanying note 224.

State Versus Federal Enforcement. A number of authors support the view that states should take the leading role in ensuring fair competition in the healthcare market.³¹⁷ In favor of that proposition comes an often-mentioned limited resource capacity by the FTC and DOJ.³¹⁸ However, state regulations are not uniform. A few states have already protected healthcare providers from federal antitrust liability.³¹⁹ Some states are in the process of carving out further exemptions.³²⁰ However, healthcare historically has been an area of heavy government intervention.³²¹ The pending repeal of “insurance immunity” under the McCarran–Fergusson Act³²² indicates that federal legislators do not have full confidence in state-driven antitrust actions.³²³ Time of change is not a proper moment to shift gears in the regulating and monitoring forces and delegate traditionally federal enforcement area to the states. Besides, more and more organizations collaborate across state lines—for example, Medicare ACOs, which often entail the development of the commercial product under the same umbrella—and that would complicate inquiries made by the states.

There are multiple opportunities to address the regulatory loopholes. This Comment does not provide a detailed recommendation on how to do so, but rather highlights the areas that require attention and revisions.

317. See, e.g., King & Brown, *supra* note 253 (suggesting the states should “complement and supplement” federal efforts).

318. Although this author was unable to find any data on the exact resources allocated to healthcare antitrust by the FTC and DOJ, it is highly unlikely that the increased number of transactions in the industry led to the staff reallocation or additional hiring.

The major issue confronting the Antitrust Division of the Department of Justice and Federal Trade Commission will not be whether litigation challenges to health care consolidation should be launched: rather, it will be identifying how their limited resources should be deployed to challenge only those transactions that most deeply offend the Clayton and Sherman Acts. If the expected increase in merger activity is greater than the antitrust agencies can handle, a number of mergers that may have been otherwise challenged may escape antitrust prosecution. CANTOR & KOURY, *supra* note 83.

319. See Sage et al., *supra* note 17, at 34 (“In recent years more than twenty states have enacted laws to protect hospitals, providers, and other health-related entities from antitrust liability.”).

320. Ramirez, *supra* note 102, at 2246 (“In some states, legislation has been proposed that would exempt health care providers that engage in collaborative activity, including joint ventures and mergers, from antitrust review.”).

321. Martin Gaynor, believes states lack incentives for healthcare organizations to communicate and coordinate and that state regulations may ultimately harm competition. Martin Gaynor, Professor of Economics and Health Policy, Carnegie Mellon University, Roundtable: Antitrust Perspectives on Evolving Provider and Payment Models, *in* WORKSHOP TRANSCRIPT: EXAMINING HEALTHCARE COMPETITION, *supra* note 240, at 126.

322. See *supra* note 67 and accompanying text.

323. See *supra* note 66.

V. CONCLUSION

FTC Chairwoman Edith Ramirez asserted healthcare will remain “a top agency priority.”³²⁴ This is an appealing idea because currently the FTC and DOJ’s joint efforts are inadequate to ensure the competitive equality of healthcare providers. Competition in healthcare moved from the traditional pricing and volume approach to the balance of quality and mere presence in the marketplace. Antitrust principles, and specifically their enforcement, have a measurable impact on the American public’s health through market monitoring, timely bans on certain transactions, and effective support of other procompetitive efforts. The FTC and DOJ will determine the direction of healthcare by having a say on whether Amazon launches a wholesale pharmacy and whether CVS acquires Aetna, creating a futuristic *one-stop shop* healthcare marketplace for its customers.³²⁵

Ensuring agencies retain their focus on the appropriate efforts and use the appropriate analytical tools is key to preserving competition in healthcare. Current antitrust regulations are outdated and fail to provide valuable guidance to new market entrants and new market developments in assessing the competition impacts.³²⁶ The new formations may be—and in most cases are—perfectly legitimate in their main goal of reducing costs while achieving high quality results. However, without a valid framework for preserving the legitimacy there is a potential loophole for the healthcare organizations to utilize. Healthcare competition desperately needs updated federal regulations to address antitrust concerns related to the dual nature of provider-payer, continuum of care, and population health management. Healthcare is an industry like any other, but it is simultaneously driven by unique developments; therefore, the “just-another-industry” approach to antitrust issues in healthcare is outdated.

324. Edith Ramirez, Chairwoman, Fed. Trade Comm’n, Retrospectives at the FTC: Promoting an Antitrust Agenda, Remarks at the George Washington University Law School Symposium: ABA Retrospective Analysis of Agency Determinations in Merger Transactions 11 (June 28, 2013).

325. It is not yet clear which agency will take the lead on the deal review. CVS is a pharmacy and subject to FTC review, whereas Aetna, as an insurance company, is subject to review by the DOJ.

326. Fiona Scott Morton believes “that while the essential laws dictating antitrust haven’t changed in 100 years, new technology, globalization, and changes like those in healthcare delivery have greatly expanded the realm of what can fall under antitrust.” Morton, *supra* note 5.

Antitrust laws are static and not easily changed;³²⁷ therefore, the first step to recognize its uniqueness is for the regulatory agencies to provide an adequate framework specifically for healthcare to acknowledge the concerns discussed in this Comment, and to provide the uniform approach for agencies to follow in reviewing healthcare transactions in the future. The agencies' policies are not binding on the courts; however, judicial reaction will follow as courts find the agencies' guidance persuasive.³²⁸ Courts are not always experienced in the economic analysis of antitrust principles,³²⁹ and the regulating agencies must take the lead in offering a comprehensive "translation" of the antitrust principles, especially in the context of healthcare that balances traditional economic well-being with the consumer's social welfare.

The future is uncertain. The ACA may or may not be repealed. Tech giants, such as Apple, Amazon, and Google, may enter the pharmacy market. The CVS–Aetna merger may or may not come through. These transactions, however, indicate the transformation mechanism in healthcare has been launched and cannot be stopped, regardless of what transpires with these deals in the future or the ACA in general. Healthcare in the United States is a business like any other; preserving its social nature and recognizing the unique antitrust challenges is paramount to the Nation's health.

327. Cohen, *supra* note 186.

328. See *supra* note 85.

329. Judge Bork's work, *The Antitrust Paradox*, is referred to as a persuasive translation of antitrust law's economic effects for "members of a Court neither trained in nor sympathetic to economic analysis." George L. Priest, *The Abiding Influence of The Antitrust Paradox*, 31 HARV. J.L. & PUB. POL'Y 455, 457 (2008). The *persuasive translator* roll shall be held by the FTC and DOJ. See *id.*